# Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

WHENE YOUVERSITY to Kn8k MLCH1GONoups

MAR 6 1959 GP vs Specialist: Is the HERRAY Ending?

+34 Obstetrics: Target for Malpractice page 100 FEBRUARY 1969

hat me orld olub-

of nia. oral ubhis

3 edi-

antin, was

ni-

to eriizandene

cut hislay.

ician

# NOW even many cardiac patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

DECADRON—the new and most potent of all corticosteroids, eliminated fluid retention in all but 0.3 percent of 1500 patients†, and induced beneficial diuresis in nearly all cases of pre-existing edema.



treats <u>more</u> patients <u>more</u> effectively Therapy with DECADRON has also been distinguished by virtual absence of diabetogenic effects and hypertension, by fewer and milder Cushingoid reactions, and by freedom from any new or "peculiar" side effects. Moreover, DECADRON has helped restore a "natural" sense of well-being tanalysis of clinical reports.

\*DECADRON is a trademark of Merck & Co. Inc. ©1958 Merck & Co., Inc.



MERCK SHARP & DOHME
Division of Merck & Co., Inc., Philadelphia 1, Pa.

ebruar

February 1959, Vol.

## Resident Physician

Articles

- What You Ought to Know About Group Practice
- 65 GP vs Specialist: Is the Battle Ending?
- 73 Guest Editorial
- 77 Clinico-Pathological Conference
- 88 Cleveland Metropolitan General Hospital
- 100 Obstetrics: Target for Malpractice
- 112 The Surgeon Who Dared the Impossible
- 126 How to Equip the Ophthalmology Office
- 140 Adventure in Drugmaking
- 160 Key Words for the Clinic: How to Speak Yiddish

he Resident Physician published monthly the fifteenth y The Resident, Inc., ith publication offices t 34 North Crystal treet, East Stroudsburg, ennsylvania. recutive, advertising d editorial offices at 447 Northern Boulevard, anhasset, New York. f undelivered, please send m 3547 to Resident hysician, 1447 Northern ulevard, Manhasset, ew York.

1959, Vol.

February

fluid

aiso

ence

yper-

shin-

from

ects.

ed re-

eing.

& Co.

hin 1, Pa.

ebruary 1959, Vol. 5, No. 2



#### The whole family likes "Premarin"

In a sense, when you prescribe "Premarin" for a wife and mother who is suffering in the menopause, chances are you're treating the whole family. Junior, Sis, and Dad, just like Mom, can tell the difference right off.

Mother isn't just more tranquil on "Premarin" therapy. Hundreds of published reports tell us she takes a positive outlook on life. She feels good. And we all know that's the single most important factor for a happy home.

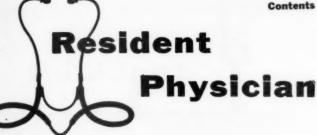
Women on "Premarin" receive treatment that covers every aspect of the menopause, including prompt relief of physical distress.

Is it any wonder physicians say the woman suffering in the menopause deserves "Premarin"? Many a family would agree.

"Premarin," conjugated estrogens (equine), a complete natural estrogen complex, is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, New York • Montreal, Canada

Febru



#### **Departments**

- Therapeutic Reference
  - Viewbox Diagnosis 23 Read the film and compare your findings with those of a top radiologist.
- Resident Relaxer 27 Sleuth or sloth? Medical crossword puzzle for word detectives.
- Letters to the Editor 34
- 53 Editor's Page
- Mediquiz 168 Working alone or with your colleagues, you'll find this is no snap.
- What's the Doctor's Name? 173 Identify this famous physician from clues in the brief biography.
- Leads and Needs 175 Practice openings; residency opportunities.
- Advertisers' Index 182 Companies whose products and services are advertised in this issue of your journal.

, and

ished ve all

neno-

serves

nplex. ate or

Article

public

standi

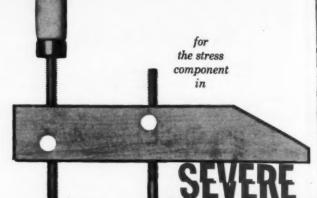
tribute

licatio

value When

of the

Febr



## STRESSCAPS'

STRESS FORMILLA VITAMINES I FOFRI F

for a more favorable

therapeutic course

Host defense mechanism—fundamental to successful antibiotic control in severe infection—and recovery of normal organic function place a stress-demand on metabolic processes. Therapeutic supplements of B and C vitamins, as the basis of enzyme activity, protein-carbohydrate utilization, endocrine response and antibody formation, are often required. 1,2

STRESSCAPS provide high levels of water-soluble vitamins to insure a better prognosis.

Each capsule contains:

Thiamine Mononitrate (B	.).	10 mg
Riboflavin (B <sub>2</sub> )		10 mg
Niacinamide		100 mg
Ascorbic Acid (C)		300 mg
Pyridoxine HCl (B <sub>6</sub> )		2 mi
Vitamin B <sub>12</sub>		4 mcgm
Folic Acid		1.5 mg
Calcium Pantothenate .		20 mg
Vitamin K (Menadione)		

- Average dose: 1-2 capsules daily.
- Daskal, H. M.: <u>Antibiotic Med. & Clin.</u> Ther. 2:33 (June) 1956.
- Pollack, H. and Halpern, S. L.: Therapeutic Nutrition, National Research Council, Washington, D. C., 1952.



LEBERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Poorl River, New York

# Resident Physician

**Editor-in-Chief** 

Perrin H. Long, M.D.

Chairman Department of Medicine College of Medicine at New York City State University of New York Chief, Department of Medicine, Kings County Hospital Center, Brooklyn, New York

Managing Editor

Robert B. Palmer

Associate Editor

John F. Pearson

Resident Staff Director

Salvatore R. Cutolo, M.D. Seymour H. Kaplan, M.D.

Contributing Editor

Edward R. Bloomquist, M.D.

Resident Editor

Production

Katherine C. Weber James F. McCarthy

Art Gill Fox Alex Kotzky

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted.

Vol.

evels of

10 mg.

100 mg

300 mg 2 mg 4 mcgm

1.5 mg

20 mg 2 mg ly. d. & Clin.

.: Thera

Research

, Row York

ysician

952.

February 1959,

RESIDENT PHYSICIAN. Contents copyrighted 1959 by The Resident, Inc. Randolph Morando, Business Manager and Secy.; William Leslie, 1st Vice President; Roger Mullaney, 2nd Vice President; Walter J. Biggs, Sales and Advertising; 1447 Northern Boulevard, Manhasset, New York, West Coast Representative: Ren Averill, Ren Averill Company, 232 North Lake Avenue, Pasadens, California. Subscription rate \$10.00 per year. Single copies \$1.00. Notify publisher promptly of change of address. in children, 'Thorazine' promptly

## stops vomiting



#### THORAZINE\*

syrup and suppositories

Smith Kline & French Laboratories

\*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

J. Al ment pital

Max partn

Deri

fesso Dern York cal S

C. W eral Univ

> GEOR Practal, 1

> WILI Med cal S

CHAI Profe cal S

C. V Prof Dear

Febr

# sident Physician

#### Anesthesiology

J. ADRIANI, M.D., Director, Department of Anesthesio egy, Charity Hospital of New Orlean.

MAX S. SADOVE, No., Director, Department of Anesthesiology, University of Illinois.

#### Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

#### **General Practice**

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program. University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore, Md.

#### Medicine

ysician

WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

CHARLES DAVIDSON, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine: Assistant Dean in Charge of Post Graduate

Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

CHARLES F. WILKINSON, M.D., Professor of Medicine, New York University Postgraduate Medical School: Director, Fourth Medical (N.Y.U.) Division, Bellevue Hospital Center.

#### **Obstetrics-Gynecology**

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

#### Ophthalmology

DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

#### **Orthopedics**

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

#### Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of lowa.

TWO NEW PARAFLEX\* PRODUCTS

FOR RHEUMATISM AND TRAUMATIC DISORDERS

# PARAFON

THE SPECIFIC MUSCLE RELAXANT PLUS
THE PREFERRED ANALGESIC

FOR ARTHRITIS

# PARAFON with PREDNISOLONE

Effective and well suitrated on the practical decage of only is under daily.

PARAFON and PARAFON WITTE PREDICTIONAL PROVIDE BEHAVIOR that last for up to the hours.

PARAFON relieves pain, stiffness, and disability caused by meaningtism and troumatic liverders. Parafon with Preprint congruences this relief with anti-inflammatory action an treatment for arthritis.

supplied: Parkyon: Tablets, sorred, pink, bottles of 50. Each rable) contains: 

Parkyon: Chiloropagescol 125 mg.; and Tyrenous Acctamic opines 300 mg.

Parkyon with Parkyonova: Tablets, socred, built volused, builtes of 56.

Each tablet contains: Parkyon Chiloropagescol 125 mg.

Tyrenot, Acctamicoches, 300 mg.; and arreducedors 1.0 mg.

recontions: The precautions and contraindifections that apply to all steroids should be kept is mind when prescribing Pararon with Parantsolove.

McNEIL

McNeil Cappratories, Inc . Philadelphia 32: Pa.

# Resident Physician

Pathology

JOHN R. SCHOKEN, M.D., Professor of Pathology Iniversity of Nebraska, Lincoln.

#### **Pediatrics**

James Marvin Baty, M.D., Physician-in-Chief, Boston Floating Hospital.

#### **Plastic Surgery**

NEAL OWENS, M.D., The Owens Clinic, New Orleans; Clinical Professor of Surgery, Tulane University School of Medicine.

#### Psychiatry

WILLIAM C. MENNINGER, M.D., Professor of Psychiatry and General Secretary, Menninger Foundation School of Psychiatry.

#### Public Health and Preventive Medicine

HERMAN E. HILLEBOE, M.D., Commissioner of Health, State of New York.

#### Radiology

MAXWELL H. POPPEL, M.D., Director of Radiology, Bellevue Hospital Center.

#### Rehabilitation and Physical Medicine

SEDGWICK MEAD, M.D., California Rehabilitation Center, Vallejo.

#### Resident Staff Director

SALVATORE R. CUTOLO, M.D., Deputy Medical Superintendent, Bellevue Hospital Center.

#### Surgery

DONALD C. COLLINS, M.D., Assistant Professor of Surgery, College of Medical Evangelists.

EARL J. HALLIGAN, M.D., Director of Surgery, Jersey City Medical Center.

KARL A. MEYER, M.D., Chairman, Department of Surgery, Cook County Hospital.

HOWARD E. SNYDER, M.D., The Snyder Clinic, Winfield, Kansas.

#### **Thoracic Surgery**

PAUL C. SAMSON, M.D., Associate Clinical Professor, Stanford University School of Medicine.

#### Urology

HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.



ACIDTYPES from the Gelusil Family Album

MOTHER

Chl

Ted

An Se

Do

Ler

Lev

Par

Pla

Ad

Ge

Ga Ilo Ka

When this was taken, Mother was lovely and poised — even though in the family way. In the genteel manner of her day, she concealed her condition well, although almost nothing could mask her recurrent "heartburn."

Today pregnancy is no secret. Nor is effective treatment of accompanying gastric upset. You can assure *your* ladies-in-waiting full symptomatic relief . . . prompt, lasting and safe . . . with pleasant-tasting Gelusil, the antacid adsorbent Mother should have had.

Gelusil is all antacid in action ... contains no laxative ... does not constipate. Prescribe Gelusil with confidence for every patient's use at home and in the hospital. The choice of modern physicians for every antacid need.



antacid adsorbent



# Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(\*).

Chlor-Trimeton Injection	Allergic	Disor	der	s a	nc	1 /	ls	th	ım	a
Tedral										
Sedatives and Anesthetics										
Leritine							ic	s		
Levo-Dromoran   170, 171     Nisentil   170, 171     Pantopon   170, 171     Pantopon   170, 171     Placidyl   174     Antacids and Intestinal     Adsorbents     Gelusil   14     Antibiotics and Chemotherapeutic Agents     Achromycin   114, 115     Cathomycin   167     Gantrisin   52     Ilosone   366										
Nisentil										
Pantopon         170, 171           Placidyl         174           Antacids and Intestinal Adsorbents         14           Gelusil         14           Antibiotics and Chemotherapeutic Agents         14, 115           Cathomycin         167           Gantrisin         52           Ilosone         36										
Placidyl										
Antacids and Intestinal Adsorbents  Gelusil 14  Antibiotics and Chemotherapeutic Agents  Achromycin V 114, 115 Cathomycin 167 Gantrisin 52 Ilosone 366										
Adsorbents         14           Gelusil         14           Antibiotics and Chemotherapeutic Agents           Achromycin V         114, 115           Cathomycin         167           Gantrisin         52           Ilosone         36	raciuyi									1/4
Antibiotics and Chemotherapeutic Agents           Achromycin V         114, 115           Cathomycin         167           Gantrisin         52           Ilosone         36			Int	est	in	al				
therapeutic Agents           Achromycin V         114, 115           Cathomycin         167           Gantrisin         52           Ilosone         36	Gelusil					4 8	× .			14
Cathomycin         167           Gantrisin         52           Ilosone         36						0-				
Gantrisin 52 Ilosone 36	Achromy	cin V						11	14.	115
llosone 36	Cathomy	cin								167
Kantrex between pages 20, 21										
	Kantrex		. be	twe	en	P	ag	es	20	), 21

Madribon Madriqid Pen•Vee K Sumycin Intramuscular	30, 31	
Antiemetics		
Thorazine	10 20	
Antispasmodics		
Butibel	39	
Arthritic Disorders as	nd Gout	
Bufferin	48	
Cardiovascular Disor	rders	
Butiserpine Diupres between Diuril Gitaligin Serpasil-Apresoline	pages 36, 37 42, 43 47	
Careers		
U. S. Army	32	

now, for the first time, liquid meprobamate





Conforms to Code for Advertising

- · in children
- · in the aged
- · in all patients who reject tablet medication

SUPPLIED: Suspension, 200 mg. per 5-cc. teaspoonful, bottles of 4 fluidounces. Also available: Tablets, 400 mg., scored, bottles of 50; 200 mg., scored, vials of 50. WYSEALS® EQUANIL, tablets, 400 mg., vials of 50.

RELIEVES TENSION-MENTAL AND MUSCULAR

Dexa

Conf Prece Rams

Coup Hyco Robit Tessa

Diag Clini Dres Vi-D

Epil Celo Dila Milo Phela

> Equ Busi Hista Stati

Gla Dian G. L

Ant Azo Fura Man Ругі Pyri Uris

Her Rec Anu

Infa Car Var

Inv Hea Insu

Feb

Central Nervous Stimulants	I. V. Solutions
Dexamyl154, 155	Albuminsol
Contraceptives	
Preceptin         41           Ramses         18	Laxatives and Anticonstipation Preparations
	Agoral 172
Cough Control	
Hycomine 22	Menopausal, Menstrual and
Robitussin AC	Premenstrual Tension
lessaion peries	Premarin 6
Diagnostic Agents	
ClinitestCover 3	Muscle Relaxants
Dressings	Parafon
Vi-Drape	Parafon with Prednisolone 12
Epilepsy	Skin Disorders and
Celontin Kapseals 35	Antibacterials
Dilantin Kapseals	Decadron 147
Milontin Kapseals	
Filefalltili Kapseais	Steroids and Hormones
Equipment and Supplies	DecadronCover 2
Business Cards* 179	Tranquilizers
Histacount* 169 Stationery* 181	Equanil
Stationery* 181	Equanii10
Glaucoma	Ulcer Management
Diamox	Aludrox SA 21
G. U. Preparations and Antiseptics	Upper Respiratory Infection
Azo Gantrisin	Preparations Cyclamycin
Furadantin 109	Madricidin
Mandelamine 131	Madricidii138, 139
Pyridium 127	Vaginal Preparations
Pyridium Tri-Sulfa 129 Urised 173	
Urised 173	Triple Sulfa Cream 121
Hemorrhoids and	Vitamins and Nutrients
Rectal Disorders	Beminal Forte with Vitamin C 4
Anusol HC 33	Deca-Vi-Sol
Infant Formulas and Milks	Nilevar
Carnalac	Poly-Vi-SolCover 4
Varamel	Stresscaps 8
	Tri-Vi-Sol Cover 4
Investments and Insurance	
Health Insurance* 49	Worms
Insurance* 179	Antepar 44

# R hidden comfort inner security





You are giving very special physical comfort to your patients with RAMSES® Diaphragm and Jelly\* because the RAMSES Diaphragm has a soft, cushioned rim and is flexible in all planes to permit complete freedom of motion, and because RAMSES Jelly is uniquely suited for use with the diaphragm. Not static, it flows freely over rim and surface to lubricate the diaphragm, add comfort, and protect patients for ten full hours.

With RAMSES Diaphragm and Jelly you are also providing essential inner security, since your patient is assured she can plan her family according to her wishes, using not only the most reliable method — diaphragm and jelly—but the most comfortable and reliable diaphragm and jelly, RAMSES. As Tietzel points out, the diaphragm-jelly method reduces the likelihood of conception by at least 98 per cent.

After fitting the diaphragm, prescribe the complete unit — new RAMSES "TUK-A-WAY" Kit #701 with diaphragm, introducer and jelly in an attractive new zipper case.

Ramses

1. Tietze, C.: Proceedings, Third International Conference Planned Parenthood, 1953.

\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness. RAMSES and "TUK-A-WAY" are registered trademarks of Julius Schmid, Inc.

JULIUS SCHMID, INC., 423 West 55th Street, New York 19, N. Y.

Febr

#### Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R., Professor of Radiology, New York University College of Medicine and Director of Radiology., Bellevue Hospital Center

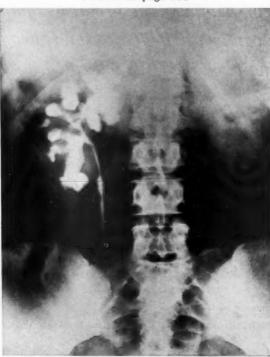


#### Which Is Your Diagnosis?

1. Tumor

- 2. Tuberculosis
- 3. Hydronephrosis
- 4. Perinephritic abscess

Answer on page 181



February 1959, Vol. 5, No. 2

23

your ecause m and om of suited freely n, add

inner
ing to
elly —
lietze1
eption
MSES

enal Connolaurate ctiveness.

, N. Y.

The prompt and effective clearing of organisms and pyuria that was obtained in this series and in a previous one with Gantrisin

relief of bladder and urethral symptoms which can be attributed to the [phenylazo-diamino-pyridine HCl] indicated to us that

AZO Gantrisin is an ideal compound for use in common urinary tract infections that we see from day to day in the practice of urology.

The synchronized therapy provided by Azo Gantrisin is highly effective against infections carried by the blood stream and the urine. Valuable also in prophylaxis before and after cystoscopy, catheterization and urologic surgery.

\*F. K. Garvey and J. M. Lancaster, North Carolina M. J., 18:78, 1957.



GANTRISIN® Brand of sulfisoxazole ROCHE—Reg. U. S. Pat. Off.

ROCHE-Reg. U. S. Pat. Off.

ROCHE LABORATORIES • Division of Hoffmann-La Roche Inc • Nutley 10 • N. J.

HOR

y the moragressive ody ertaining clyster he soul senus of nert gase reighted welling owest (L labit spanwardly merican

nwarcaly
merican
ustic
His med
acilli
covered
yymbol fi
kill
Wool (La
Name for
Yenezuel
His dilah
teri
Wing
Any labiu
New York
Meaningl
Body in c
City in S.

Was ena Sexually Factor in To free Radium Swelling The finess Alopecia High Pri Sohes th Latin for Asian pe Volatile Sends for Banishme A tenth, Task Loose-fitt

Sea eagl Decorati

Surgical
"A man
than him
Pertainin
Relation
prefix

Feb

#### HORIZONTAL

ing

as

nis

tic

ms

-05

at

eal

ict

\*

tive

also

ogic

1957.

N. J.

cian

y the mouth (2 wds.) regressive atrophy of the ertaining to the sun lyster he soul enus of Asiatic palm trees nert gaseous element reighted welling owest (Lat.) labit spasm nwardly merican Indian ustic his medium for typhoid overed with frosting Wool (Lat.) Name for skin disease Venezuela) His dilator for the cervix enus of ticks art of "to be" Wing Any labium New York neurologist New tork neurological Meaningless word Body in cell protoplasm City in S. Turkey ntention Colloid Miss Novak of the movies Famous for its "Santa Casa" (Italy) Was enamoured of Sexually attractive (Adj.) To free Radium (Chem. symbol) Swelling of the feet The finest sauterne wine Alopecia areata High Priest of Israel Soils Sheep thrush Latin for foot Asian perennial plant Volatile oil Sends forth Banishment A tenth, in Scotland Loose-fitting dresses

#### VERTICAL

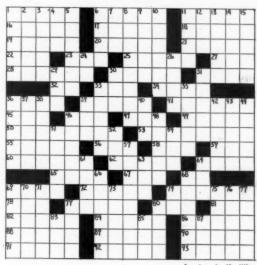
Sea eagles

Surgical fixation "A man has no .... w than himself" (Cicero) Pertaining to the kidney Relation to the shoulder; prefix

Decorative metalware (pl.)

#### Resident Relaxer

(Answer on page 181)



by Angela Koelliker

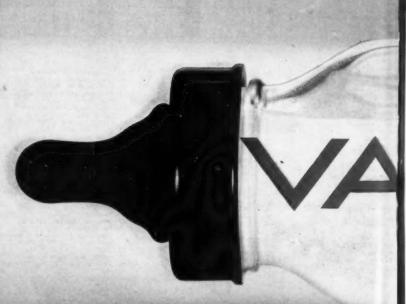
- 5. True sandalwood 6. Powdered soapstone
- 7. So much of each
- 8. Affecting two teeth
  9. Correct
  10. Colorless, crystalline

- principle
  11. Loose granular material
  12. Mouth: combining form
  13. French physicist (1853-1939)
  14. Not chronic
- 15. Erased (now rare)
- 24. A negative prefix
- 26. African venereal disease 29. Strive for superiority
- 30. Unit of work
  31. Process: word termination
  33. Root of a Brazilian plant
- 35. Dorsal 36. Tubular passage 37. Grain blight 38. Resembling a web-like
- tissue
- 39. -ben Iza
- 40. Drink in small quantities 42. Gaseous product of
- burning 43. Commingle 44. Disreputable

- 46. Variegated chalcedony 48. Sought out in a hotel 51. Lake in N.W. Russia 52. One-thousandth part of a
- liter
- 54. "The bugle-cry of —'
  (J. K. Huysmans) Color
  57. French surgeon (1869-1919)
- 61. Technical term

- 61. Pechnical Term
  63. Yigor
  64. Salt
  66. To make equal
  68. Induce recovery
  69. Cylindrical muscle
  70. Proprietary laxative
- 71. Mimetic 73. Express
- 74. Prism (abbr.) 75. Clear, volatile oil 76. Contemporary Hungarian
- physician 77. Beast of burden (pl.) 79. Perceives
- 80. Operation for breaking up fresh adhesions in joints 83. Kind
- 85. Once; dial. vars. 87. Unit of electric conductiv-

The only major change in flexible formulas since evaporated milk

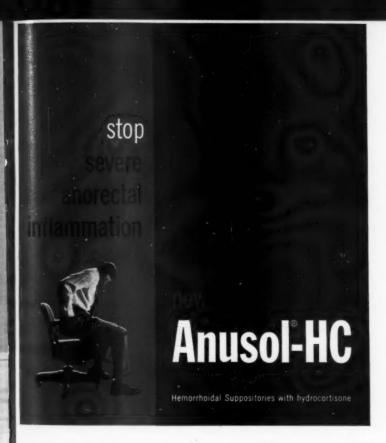


140

Start anor 3-6

posit regin symp

Febru



Start with steroid therapy for effective and safe control of severe anorectal inflammation. Two Anusol-HC Suppositories daily for 3-6 days reduce and eliminate pain, heat, swelling and redness. Then patient comfort can be maintained with regular Anusol Suppositories or Unguent as required. This simple Anusol-HC/Anusol regimen assures rapid, lasting relief of all inflammatory symptoms in hemorrhoids and other anorectal disorders.

#### Letters

#### to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.



#### Over-specialization

Your October "Resident Roundtable" is a classic. It should be required reading for every physician. If it were a novel, it would be a flop: the plot is fantastic and the characters are unbelievable. The tragedy is that it is fact and not fiction.

A board-qualified pediatrician who can't read EKG's and never treated an outpatient with diabetes; a five-year man in "general" surgery who barely knows how to set a fracture; a rotating intern whose experience in internal medicine was limited to diabetes and tuberculosis (except for one glorious month of "general" medicine): these travesties are not educational rarities—more and more they are becom-

ing the pattern. And who sets the pattern? The Doctor Kerrs, who can't understand how their "interest" in a subspecialty can possibly affect the training of residents in more general fields. Yet they admit to union shop practices that show clearly just where their interest lies.

The general practitioners have been all alone on the short end of the stick for quite a while. Now it appears to be getting crowded with other doctors whose specialties, are becoming too general for our enlightened, scientific age.

It is too much to hope that we will soon see the folly of our ways and once more generalist and specialist (yes, and subspecialist) will work hand in hand

-Continued on page 38

"a new and nearly ideal skin drape...
skin adherent to the incisional edge."

Apply over operative area then

INCISE RIGHT THROUGH FILM

# A new aid to aseptic surgery... Vi-DRAPE Surgical Film

... completely isolates the patient's skin from the wound and maintains the sterility of the operative site. Skin draping by this method eliminates the use of cumbersome cloth skin towels and towel clips. Nothing used during the operation can touch uncovered skin.

A soft, sterilizable, pliant plastic, Vi-DRAPE Film is adhered to the surgically prepared skin with sterile Vi-HESIVE® Surgical Adherant and the incision made right through the transparent film. The adhered film clings closely to wound edges throughout the procedure and is impermeable to bacteria and fluids. Applicable to all contours, Vi-DRAPE Film offers extra advantages in achieving asepsis in previously difficult-to-drape areas.

Use of Vi-DRAPE Film fits easily into established routines of the surgical team. For literature and technic-for-use, write to:

AEROPLAST CORPORATION 420 Dellrose Ave., Dayton 3, Ohio.

who "inpos-

resi-

Yet

rachere

have

end

hile.

tting

hose

too

ened.

our

ralist

bspe-

hand

ge 38

sician

Vi-Drape Film and Vi-Hesive Adherant are available through your surgical supply dealer. In Canada, through Fisher and Burpe Ltd.
Patents Pending

1. Adams, Relph, M. D.: Med. Times, 86:1119-1127 (Sept.) 1958.

Initial clinical studies on Vi-DRAPE Film were conducted by Gart Walter, M.D., Peter Bent Brigham Hospital, Boston.

and for post-op use
AEROPLAST®
Spray-on Surgical Dressing

#### -Continued from page 34

for the common good of all? Or are there too few doctors left whose primary "special interest" is the patient's welfare?

Keep up the good work! Resident Physician is always interesting and frequently stimulating.

Louis F. Rittelmeyer, Jr., M.D.

Associate Professor
Director, Section on
General Practice

University of Mississippi Jackson, Mississippi

• I am completely in agreement with your statement that the tragedy of "Resident Roundtable" published in the October issue of RESIDENT PHYSICIAN is that it is fact and not fiction.

To me, the fault, if one should call it a fault, lies in the fact that only too often the service needs of a hospital govern its intern and resident policies. I have frequently commented that some of the so-called "rotating internships" in this country are so set up that the poor intern whirls through the various services like a dervish, and on these one month assignments is known as "hey, you!"—and at the end of his year it is hard for members

of the staff to remember his name, if they can recall it at all. In the field of the residencies, I decry the tendency towards specialization. Some of these residencies, which are set up in violation of the tenets of graduate education, provide nothing but services in subspecialty after subspecialty; or for the benefit of the attendings the service is broken up into cardiac wards. metabolic wards. endocrine wards, GU wards, etc., to a point where no one gets any education in general medicine. Personally, I would be in favor of limiting all subspecialization in medicine or pediatrics to individuals who had completed the full general residency for those specialties.

The correction of these defects in our graduate system of education rests primarily with the chiefs of service and the senior attendings. Hospital administrators bear a very important secondary responsibility in that they should exercise their authority to see that the intern is not considered to be but another pair of hands, and that the resident training is in the general subject rather than in the subspecialty.

P. H. L.

ho

vmpt

or pr

ronc

edral I delayed with the

-Concluded on page 46



mptom-free with Tedral...the safe, effective, low-cost antiasthmatic designed or prolonged therapy. No single drug can equal Tedral in protecting against ronchial constriction, mucous congestion, and apprehension 'round-the-clock.

osage: 1 or 2 Tedral blets q.4.h. plus 1 or 2 edral Enteric Coated felayed action) ith the regular dosage bedtime,

ident

bject

ilty.

H. L.

ge 46

sician

his t all. es, 1 speresivioluate but after fit of e is ards. crine point ation ially, iting icine who neral es. fects lucathe enior strasecthey ty to nsidir of

### TEDRAL

the dependable antiasthmatic



#### -Concluded from page 38

#### **Narcotics and Malpractice**

In view of the recommendation by a joint committee of the American Medical Association and the American Bar Association that non-medical addicts be furnished narcotics to maintain their addiction, I submit the following striking example of the consequences of such a procedure:

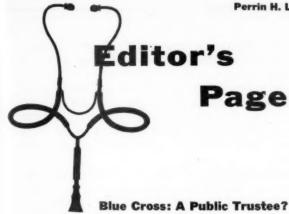
A patient in an eastern city recently brought suit against her physician for malpractice and damages because of her addiction which resulted when the physician administered to her excessive quantities of morphine over a period of six years. She alleged that she was forced into prostitution to pay the physician. The AMA-ABA committee used the argument that by furnishing narcotics to addicts, it would not be necessary for the addicts to resort to crime and prostitution to pay the peddler.

As a result of this action the plaintiff recovered a substantial sum of money in damages.

H. J. Anslinger Commissioner of Narcotics Washington, D.C.



Feh



One of the trends which is becoming increasingly evident in the negotiations between unions and employers for wages and welfare ("fringe") benefits is the growing emphasis being placed on health and medical care. Indeed, from what were then considered small beginnings, such as the health center of the International Ladies' Garment and Amalgamated Clothing Workers unions, we have seen the development of comprehensive medical services such as the United Mine Workers' overall plan for medical care, which includes not only total medical care for the miners. but also for their dependents as well. Under the mine workers' plan, ambulatory and hospital care are provided, and also consultative services and medical care and treatment in such medical centers as the Johns Hopkins Hospital and other well known institutions. And mind you, this is provided without any direct contribution on the part of the miner or his family. This plan is financed by what amounts to a fixed levy on each ton of coal mined, paid by the mine operators with the cost passed directly to the consumer. (Pensions and other benefits are also paid out of this fund.)

February 1959, Vol. 5, No. 2

53

ysician

her

She into

cian. used hing

not s to

the

nger

otics

During the recent convention of the United Steelworkers much thought and discussion concerned the possibility of the union setting up a system of medical care for union members and their families, to be financed and operated in a manner somewhat similar to that of the United Mine Workers. A comparable type of program has also been seriously considered by Walter Reuther's United Auto Workers. Other unions are eyeing such schemes with interest.

Considerations such as these are of the greatest importance to the medical profession, and to hospital administrators and trustees, because they constitute a direct threat to existing Blue Cross and Blue Shield plans. For example, if the steelworkers set up their own hospitals and medical services, it is estimated that Blue Cross would lose a block of one million subscribers. If other unions adopted similar programs, Blue Cross-Blue Shield programs in our country might well be wrecked.

What is back of these moves on the part of the unions is worth exploring. The rising costs of medical care under Blue Cross-Blue Shield programs constitutes one of the chief concerns of the unions. For example, when the steel-workers made it clear that they were "by no means... satisfied with the reasons given by the sky-rocketing costs of our hospitalization and medical care programs" they were echoing some of the views expressed by the Commissioner of Insurance for the State of New York during hearings last spring on the question of increasing the rates paid by subscribers for coverage by Blue Cross. It also must be noted that the subscribers themselves have been expressing similar views recently.

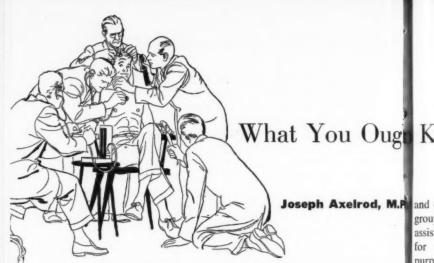
This dissatisfaction with the mounting costs of Blue Cross-Blue Shield protection should be considered ominous because these plans have been the best answers found yet to the continued pressures for Federal National Health

Insurance and other bureaucratic and restrictive, closed types of health schemes. If Blue Cross-Blue Shield fail, the outlook for the survival of other types of voluntary insurance plans is indeed bleak.

The answers to the problems faced by Blue Cross are not easy ones to determine. However, one thing appears clear, and that is that Blue Cross must stop thinking of itself as an organization solely conceived for the purpose of paying subscribers' bills to hospitals and realize that one of its first concerns should be with keeping hospital costs as low as possible for its more than fifty million subscribers.

As Blue Cross is now the single greatest source of current income to voluntary hospitals, its role as the public's trustee in hospital affairs should be carefully maintained. and in its subscribers' interests. Blue Cross could and should insist on efficient administration, modern budgeting and cost-accounting practices, reasonable personnel policies, proper purchasing methods, etc. on the part of its member hospitals. This it owes to its subscribers, and if Blue Cross and Blue Shield are to survive, and the practice of medicine and the provision of medical care in this country not be dominated by bureaucratic and restrictive organizations, then the ultimate consumer of the Blue Cross-Blue Shield services, i.e. the subscriber, must be satisfied. Otherwise the health and medical care of large segments of our population, and the physicians who provide this care will become the captives of a restrictive, bureaucratic system.

Perin H. Long,



Will you strike out on your own in the private practice of medicine? Or will you join with other physicians, share facilities, office personnel and practice medicine in a unified administrative and financial setup? The choice is important. It deserves your most careful consideration of the facts of practice life.

Despite what you may have heard, group practice is not Utopia. In fact, some of the most glowing comments concerning this fast-growing form of private medical practice spring from physicians in solo practice, doctors who envy the supposed advantages of group practice, but who are almost totally blind to the disadvantages.

Group practices vary widely. They differ in size, organization, control, composition and operation. But there are certain characteristics common to all groups.

As a house officer, you are currently in "hospital practice," experiencing some features of the group practice. You share with other doctors your professional skills, utilize common facilities

and grou assis for purp

A ing c leagu the r invo and fello ant a

H exist grou the prac T

grou orga and ices. patie of si what

Febru

#### oug Know About Groups

and equipment. You are like the group practitioner in that you are assisted by "subsidiary personnel for administrative and clinical purposes."

Also, you are presently working on a full-time basis with colleagues in other specialties, share the responsibility for patients, are involved in frequent consultations and find cooperation with your fellow residents an easy and pleasant association.

However, a basic difference exists between residency and group practice: competition and the financial rewards of private practice alter the ideal picture.

idely.

ation,

pera-

char-

roups.

u are

ctice."

of the

with

sional

cilities

ysician

The existence of medical groups, their reasons for being, organization, administration, fees and income, location, staff, services, advantages to doctors and patients, obstacles, and the causes of success and failure, as well as whatever future this method of

practice may have, all have been subjects of considerable study and discussion. Much is already a matter of statistical record concerning group practice in the United States.

#### Definition

As a general definition, group practice may be termed the formal association of three or more physicians who share their professional skills and resources in the care of patients, who make joint use of equipment and facilities, employ technical and administrative personnel in common, and have a unified administrative and financial organization.<sup>2, 3</sup>

In some specific detail, these are the characteristics commonly present in medical group practice:

 Sharing of facilities such as office space, examination and

February 1959, Vol. 5, No. 2

57

consultation rooms, x-ray equipment, laboratory and other equipment in a group center.

Physicians include both general practitioners and specialists.
 A few or most of the specialties and subspecialties may be represented.

 Physicians are on a fulltime basis and derive their professional incomes almost solely from the group practice.

 Patients are freely referred within the group for consultation. Competition is absent among the group's physicians; a cooperative effort is in evidence.

• The financial transactions of each patient are with the group as a whole, regardless of whether he has been served by one or several group physicians.  Physicians share in the group income by contractual arrangement among themselves, not on individual fee-for-service basis.

phys

a gro

and

com

the o

sole

by a

recip

may

com

labo

tion

and

prof

pita

Con

ical

sidi:

Typ

on

serv

ing

hos

SCO

tion

The

typ

Pla

Feb

N

H

C

In

 The primary function of the group is to provide medical care; research and medical education may be collateral activities.

 Administrative and financial matters are handled by a business manager employed by the group.<sup>4</sup>

#### Ownership

Descriptive classifications can be used to identify group practices. According to owner-sponsorship,<sup>5</sup> the following are types of groups.

Private groups. Ownership and authority vested in one or more

About the Author A graduate in chemistry of the University of North Carolina, Mr. Axelrod worked for a number of years as an industrial chemist prior to entering the Air Force during World War II. In 1949, he assumed his present post as administrator of the Montefiore Hospital (New York City) Medical Group; the first

such group in the country to be formally organized as a department of a voluntary hospital. The author took a leave of absence for a year's study at Yale University leading to a Master's degree in Public Health. He majored in medical care administration. Completing his studies at Yale in 1951, Mr. Axelrod resumed his position as administrator of the Montefiore Group composed of 52 physicians and serving 25,000 insured patients.

physicians practicing together as a group.

the

actual

elves.

ervice

of the

care:

cation

finan-

by a

ed by

s can

prac-

spon-

types

p and

more

Industrial groups. Ownership and authority by a commercial company, with the employees of the company as the principal or sole patients.

Consumer groups. Ownership by an organization of potential recipients of medical care. These may be employees of a single company, consumers cooperative, labor union or similar organization.

Hospital groups. Ownership and authority vested in a nonprofit, voluntary community hospital.

Medical-school faculty groups. Control by a university or medical school, or in one of its subsidiaries or components.

Government groups. Federal, state or local governmental agency.

#### Type of service

A simpler classification, based on the scope and type of medical services offered would be:

Service groups. Groups providing continuing home, office and hospital care of comprehensive scope, including general practitioner and specialists' services. The best known groups of this type are the Health Insurance Plan groups in New York City,

#### **GROUP START**

A tornado in Rochester, Minnesota, in 1883, with its destruction and casualties was probably responsible for the establishment of the first modern group practice.

Four years later, W. W. Mayo and his two sons established the clinic which, by its growth and success, has encouraged the formation of medical groups generally.

The first real spurt in group formation, however, did not occur until immediately after World War I, probably as a result of the military medicine experiences of a number of physicians. Another sharp increase was observed after the recent war.

the Kaiser-Permanente groups in California, the Group Health Association in Washington, D. C. and the Labor Health Institute of St. Louis.

Reference groups. Groups of specialists providing episodic diagnosis and care to referred patients as their principal activity. The Mayo, Lahey, Cleveland and Ochsner Clinics are well known examples.

Diagnostic groups. Groups concentrating on diagnosis, providing little or no treatment; us-



ually reporting their findings to referring or family physicians for follow-up.

#### Private-service

Private-service groups, because they constitute about 95 percent of all existing medical groups in the United States, will be the exclusive subject of further discussion here.

#### **Expansion and efficiency**

Physicians in group practice most commonly express their conviction that the high quality medicine practiced in a group is the reason for their choice of this method of practice. Actually, groups are usually formed by three or four physicians who pool their practices and employ assistants simply because their solo practices have grown too large to handle.

grou

less

over

town

fact.

prac

late

adja

ratio

in f

loca

Per

anc

forn

hav

Sta

gro

are

full

app

me

gro

min

tive

sta

by

low

pro

ger

gyı

Fel

7

N

Another basic impetus to group practice is inefficiency in the use of office space, equipment and personnel in solo practice.

Sharing overhead costs often permits groups of physicians to improve the quality and quantity of facilities and personnel and to make economies which can be passed on to patients.

#### Location

Group practices usually locate in the community (and usually in the immediate neighborhood) of the founding physician and his original partners.

Although the most reliable information is almost ten years old,7,8 there is good reason to believe that the geographical distribution of groups has not materially changed. At that time, of 368 groups surveyed (349 servand 19 reference type groups), roughly 45 percent were located in the Midwest, a fourth each in the South and the West, and under 7 percent in the Northeast region of the United States.

physiphysiectices leady bely behave to

ncy in equipprac-

ans to antity and to an be

locate ally in od) of ad his

years on to al dismatene, of serv-

type ercent est, a nd the in the Jnited

ysician

Nearly 60 percent of these groups were in communities of less than 25,000 population and over 80 percent in cities and towns of less than 100,000. In fact, 47 percent of the group practices were operating in isolated semi-rural communities not adjacent to large cities. This last ratio has probably been altered in favor of urban and suburban locations by the growth of Kaiser-Permanente and Health Insurance Plan groups in recent years.

Minnesota, Wisconsin, California and Texas are now challenged by New York as the states having the most groups.

#### Staff, specialties

About half of the medical group practices in this country are still small, with three to five full-time physicians.

The mean size of groups is approximately ten physician members; this size in service groups is generally considered the minimum necessary for an effective group practice.

Groups tend to increase in staff as the practice ages, usually by addition of other specialties.

In order of frequency, the following specialty services are provided in medical groups: surgery, medicine, obstetrics, x-ray, gynecology, pediatrics, otolaryngology, ophthalmology, and dentistry.

Physicians in group practice recommend, and recent trends evidence increased inclusion of orthopedics, urology, dermatology, psychiatry, pathology, anesthesiology, neurology, gastroenterology, proctology and physiatry, in that order.

#### Hospitals

Between 25 and 30 percent of service type group practices own and operate their own hospitals—which average under 100 beds. The majority of group-owned hospitals are located in communities with less than 5,000 population; and about one-fourth are located in communities of 10,000 and over.

In groups which do not own hospitals, it is essential and common that all group doctors work in the same one or several hospitals.

#### Services

The following tables, perhaps atypical, are drawn from the experience of a group practice associated with an urban voluntary hospital. However, they serve to approximate the relative utilization of general medicine, pediatrics and consultant specialists' services.

#### One Group's Annual Service Experience

#### PHYSICIANS' SERVICES Per 1000 Patients Per Year

#### SERVICE

General Medicine	2310
Pediatrics (Ages 1-9 yrs.)	880
Radiology (diagnostic)	640
Allergy	440
Obstetrics and Gynecology	380
Ophthalmology	300
Orthopedics	290
Dermatology	200
Surgery (General)	200
Otolaryngology	190
Internal Medicine	170
Psychiatry	120
Radiology (Therapeutic)	80
Urology	70
Neuropsychiatry	50

#### DIAGNOSTIC SERVICES Per 1000 Patients Per Year

#### **PROCEDURE**

Hematology	70
Urinalysis	65
X-ray (body parts x-rayed) -	64
Chemistry	17
Electrocardiography	12
Serology	11
Bacteriology	6
Basal Metabolic Rate	2
Pathology	1.
Audiometry	1

Radiotherapy and physiotherapy, in the same group experience, were utilized at the rate of 14 and 54 services per 1000 patients a year respectively. In the same period, the group performed 300 deliveries, 350 major and 550 minor surgical procedures — these procedures including all surgical specialties and subspecialties.

#### Organization

Partnership is the most common organizational form of group practice; usually there are additional physicians employed who are not partners.

The partner-physicians usually own the physical assets of the group, often as stockholders in a corporation established for that purpose.

Rarely are all partners of equal rank in terms of income, ownership or authority.

Founding partners, senior partners, junior partners, probationary junior partners and employed physicians may all be group staff members. However, more commonly only senior and junior partners plus employed physicians make up a service group.

The founding or senior partners are the organizers of the original group, invest the necessary capital, retain the major authority, ar

to a land often tunity based marks

In ners in investigation with the second sec

ployed a specific offer leave

Pr

Conf

tive, of t senion men mitt dire

> of g are tuni

> > Febr

ity, and usually receive the larger shares of net income.

ther-

peri-

te of

1000

. In

per-

ma-

pro-

s in-

alties

com-

are

oyed

sual-

f the

in a

that

qual

ner-

part-

ion-

oyed

staff

om-

nior

iysi-

oup.

art-

the

sary

hor-

ician

of

Junior partners may share, but to a lesser degree in investment and authority. They are most often salaried, with some opportunity to share in net income based on work volume, but have markedly limited authority.

In some groups, junior partners may gradually increase their investment and attain senior status with all of its perquisites. The junior partner most frequently has an increasing participation in responsibility and authority as well as share of net income as his tenure is extended.

Probationary junior partners are those physicians newly-employed by an existing group for a specified trial period. After this period a junior partner is either offered a junior partnership, leaves the group, or is separated.

#### Control

Authority in the administrative, financial and policy matters of the group is vested in the senior partners as such or as members of an executive committee with or without a medical director.

In policy matters and subjects of general concern, all partners are usually consulted, with opportunity for full discussion. Most groups do have a medical director who is a founding or senior partner. He is elected by his colleagues or, in some instances, occupies the position by virtue of his seniority. His authority and duties vary with the partnership contracts and their terms which define the director's position. The smaller the group, the greater the authority of the director, and vice versa.

#### Manager

All but very small groups employ a lay administrator or business manager. His qualifications and duties may vary from secretary-bookkeeper to accountant-medical administrator. Consequently, the business manager's authority and responsibility varies.

His function is to assist the medical director or the executive committee in the areas of his special skill and training. The business administration, personnel, purchasing, statistics, and fee collection are most often the fields of the business manager's effort. He has no authority in professional matters, but assists in the coordination of the medical and the business aspects of the group practice operation. His success is measured in terms of efficiency and economy, both technical and professional.

#### References

- Moore, J. E. Staff Offices as Tried Alternative To Group Care. Hospitals 17:47, 1943.
- Hunt, G. H. Medical Group Practice in the United States, New England Journal of Medicine, 237:71, July 17, 1947.
- 3. Roberts, K. Solo or Symphony, 1946, Med. Admin. Service, Inc., 1790 Broadway, New York 19, N. Y.
- 4. Rorem, C. R. Economic Aspects of Medical Group Practice, The Kings-Med. Admin. Service, Inc.
  - 5. Hunt, G. H. Medical Group Prac-

- tice in the United States, New England Journal of Medicine, 237:71, July 17, 1947.
- 6. Esselstyn, C. B. Group Practice with Branch Centers. New England Journal of Medicine, 248:488, 1953.
- 7. Hunt, G. H. and Goldstein, M. S., Medical Group Practice in the United States, 1951, Public Health Service Publication 77, U.S.G.P.O., Washington, D. C.

IS

Medi

that

eenth

in m

ture

well
to n
mano
train
or h
penss
Th
a be
if an

Febru

Ar

8. Falk, L. A. Medical Group Practice, Public Affairs Quarterly, XII:2, Autumn, 1949, Dalhousie University, Halifax, Nova Scotia, Canada.

The second article on group practice will be published in RESIDENT PHYSICIAN next month. We will see how income is distributed, why some groups fail, and some of the important questions you should ask before joining any group.

# GP vs Specialist:

## Is the Battle Ending?

Medicine's age-old conflict continues. But there are signs that differences may be resolved in the not too distant future.

Lester S. King, M.D.\*

The second of two articles

By the second half of the eighteenth century, technical training in medicine was becoming more and more important, general culture less and less.

Anatomy, chemistry, botany, materia medica, physiology, as well as medicine and surgery, not to mention midwifery, all demanded attention. And practical training through apprenticeship or hospital teaching was indispensable.

The apothecary was acquiring a better medical education and. if ambitious, could secure the coveted M.D. degree, and the license of the College of Physicians.

Or a young man, especially outside of London, could qualify as a surgeon and do essentially general practice; he could be both apothecary and surgeon.

This growth of opportunity, however, and the more widely diffused university technical training, did not witness a comparable development of liberal education, at least, not by the old Improved technical standards. education spread very widely among all forms of medical practitioners, liberal education only

ngland ly 17. e with

rnal of M. S.

United e Pub-. D. C. actice. utums. Nova

ysician

<sup>\*</sup> Pathologist, Illinois Masonic Hospital, Chicago. Clinical Professor of Pathology. University of Illinois College of Medicine.

to a much less degree. Only the College of Physicians continued to require a high cultural level for fellowship; in fact, the cultural standards were often higher than the professional.

The other orders, the licentiate physicians, the surgeons, and to a lesser extent the apothecaries, might indeed be well educated—some were in fact fine scholars—but the general level was by no means equal to that demanded for fellows of the College of Physicians.

#### Friction

During the long struggle for power, squabbling was interminable. Multiple groups competed against each other, the friction intensified through lack of centralized or clearly defined powers. Various charters contained provisions that were sometimes unwisely limited, sometimes conflicting, sometimes subject to sweeping exceptions. There was too much overlap in one area. complete lack of regulation in another. And legal opinion was not clear regarding exact limits of jurisdiction.

Granted that some sort of license was needed for the various grades of practitioners, there were, even in the nineteenth century, no less than seventeen agencies that claimed the right to bestow licenses. The scope for confusion, irregularity and competition was truly monumental.

#### Special privilege

For example, despite regulations governing surgeons and apothecaries, there was a special privileged group that claimed exemption, namely, retired army and navy surgeons. Military personnel have traditionally sought special privileges to ease their return to civilian life. The eighteenth century was no different from the twentieth. By a law passed in 1749, certain retired army and navy surgeons were exempted from control by the Company of Surgeons. This was part of legislation to allow retired military personnel to set up in trade without any apprenticeship. In 1763 a further law extended the exemptions to wives and children of such personnel. This was a severe blow to the entire apprentice system, in all the various trades. Perhaps it was quite desirable to break the monopolistic power of tradesmen's corporations, but the move ran counter to the simultaneous struggle to enforce better medical standards. There was no way to improve standards except through the corporations such as the Company

of St by th milita

tende geon in 1 Seve can lithe many civilia leonition. were periesurgian

com

C

train

less,

in ci

mili form with grou regu pren is o pora star

not type refe of Surgeons, which was hobbled by the special privileges to the military.

to be-

r con-

mpeti-

egula-

pecial

ed ex-

army

y per-

ought

eir re-

eight-

ferent

a law

etired

re ex-

Com-

s part

etired

up in

eship.

ended

chil-

s was

e ap-

rious

e de-

olistic

pora-

unter

le to

lards.

prove

e cor-

pany

rsician

and

This freedom from regulation tendered to retired military surgeons was extended still further in 1784. Thus, the end of the Seven Years War and the American Revolutionary War witnessed the release from the service of many "doctors," to flood the civilian communities. The Napoleonic wars aggravated the situation. A few of these practitioners were well trained and quite experienced, but others were only surgeon's mates, having no civilian apprenticeship and but poor training in the navy. Nevertheless, they could set up in practice in civilian life, exempted from the requirements which held their competitors to higher standards.

#### Status quo

Quite obviously the retired military and naval personnel formed a strong pressure group within the medical community, a group that would resist change, regulations, or infringements of prerogative. The privileged group is quite familiar to the contemporary scene. We can understand their motives, even if we do not necessarily sympathize. This type of practice made any general reform extremely difficult, when

we consider that there were many different pressure groups, each bent on preserving itself regardless of the general welfare.

It would be very pleasant to think that the highest, most cultured group, the best educated, with the greatest tradition, would take the lead in producing reforms. Actually, the exact contrary occurred. The fellows of the Royal College of Physicians enjoyed the highest status of all medical practitioners, but they seemed concerned principally with guarding their own privileges, and maintaining all prerogatives against the onslaught of "lower" orders.

After all, those at the top had nowhere else to go except down. Since this they did not want to do, they could at best only maintain themselves in status quo.

The notions that there was infinite scope for general scientific advance, or that the entire medical profession could be improved all along the line, were conspicuously lacking. One of the most disgraceful episodes in medical history is the chicanery, at the end of the eighteenth century, whereby the fellows of the College of Physicians tried to keep the licentiates from gaining any voice in the organizations. Like some present-day organizations,

the College of Physicians was predominantly against whatever threatened their prerogatives, but were not for any general progress or public well-being.

#### Competition

At the same time the apothecaries faced certain crucial problems. Having in the previous century achieved considerable status they themselves now faced competition from below. When they won the right to practice medicine, and no longer were legally restricted to filling prescriptions and carrying out orders, they achieved a great advance.

But during this century of advance, they devoted themselves less and less to furnishing drugs. There was a further development of chemists and druggists who not only filled prescriptions, but in addition aspired to prescribe as well as dispense. In other words, as the apothecaries (and the surgeons) came to be essentially general practitioners, there was established a new frontier. on a lower professional plane, where competitors sought to nibble away at established prerogatives.

By the early nineteenth century the druggists and chemists offered serious competition for the apothecaries, reminiscent of their own competition with the physicians a century before.

#### Minimum requirements

Despite the undoubted progress that had been made, there were in the early 19th century, many serious abuses. It was alleged . . . "that diplomas were too carelessly given; that too many men found it too easy to become doctors, so that the profession was overcrowded; that the emoluments of doctors were reduced by dilution; that unqualified army doctors from the Napoleonic wars were settling in practice; that dangerous imposters were sharing in medical practice; that vast quantities of empirical medicines were being sold; and that chemists were prescribing for the sick."\*

As early as 1806, there was agitated a reform bill whose provisions indicate contemporary practices. The bill sought to establish certain minimum requirements for the various degrees in the medical hierarchy:

 Physicians should have studied "physic" for five years, have graduated from a university in

years years study

least appro

ship.

to se

Stan Ti ing a

eral

some achie spec apot cour coultice. lay o

pect know certi

pria

apol

omy

Febr

<sup>\*</sup> Newman, Charles. The Evolution of Medical Education in the Nineteenth Century. Oxford University Press, 1957, P. 58,

Great Britain, and be at least 24 vears old.

· Surgeons should be at least 23. should have served a fiveyear apprenticeship, with two years attendance in a school to study anatomy and surgery.

· Apothecaries should be at least 21, have served a five-year apprenticeship, and have studied "physic" in a school for a year.

· Chemists and druggists were to serve a five-year apprenticeship.

This bill did not pass.

#### Standards

There was considerable jockeying and political activity over several years, and not until 1815 was some partial measure of reform achieved. A new law regulated specifically the licensing apothecaries, and established a court of examiners which alone could grant certificates for practice. This examining board could lay down specific regulations, and thus was able to establish appropriate standards to which all apothecaries had to conform.

"Candidates were to be expected to posses a competent knowledge of Latin; to produce certificates of having attended two courses of lectures on anatomy and physiology, two on the theory and practice of medicine, one on chemistry and one on materia medica, of six months' attendance on the practice of a public hospital, infirmary or dispensary, and of five year's apprenticeship to an apothecary."\* Later, requirements in physiology, botany and midwifery were added.

Apothecaries, under the new legislation, were able to make quite satisfactory progress. Not so the other orders. Surgeons encountered great difficulty. The Company of Surgeons, established in 1745, had disintegrated by the end of the century and a new corporation, The Royal College of Surgeons in London, took its place in 1800. A reactionary group exercised strict control, electing their own successors and effectively excluding the general membership. The high-handed methods aroused considerable protest, and gradually became modified and eventually abandoned, but only under continuous pressure.

The physicians also, represented in their Royal College, continued a reactionary course. During the first half of the century there were in addition many quacks and charlatans, as well as poorly trained individuals and

1 res dehy:

physi-

progthere

ntury,

as al-

were t too

isy to

pro-

that

were

quali-

Napo-

prac-

osters

actice:

pirical

; and

ng for

was

e pro-

orary

ht to

studhave ty in

ion of teenth 1957.

ysician

<sup>\*</sup> Ibid. P. 74.

cultists such as the homeopaths.

The struggle among all these conflicting groups make a painfully confused story. Maintenance of privilege, protection from encroachment, seemed the guiding motives.

Legislative activity tried to correct the evils, but the detailed history, the moves and countermoves, are rather difficult to untangle. It was not until 1858 that a reasonably satisfactory compromise was achieved, and a General Council of Medical Education and Registration was established which could define qualifications in different branches, and set standards and examinations. Although the Council was in essence advisory, it did set up a category, Registered Medical Practitioner, bestowing on qualified individuals the privileges of practicing all the different phases of medicine and, moreover, practicing in any part of the country without local restriction.

Through setting appropriate standards there was assured a minimal overall competence. The general practitioner as we know him today became a reality. At the same time the College of Physicians and College of Surgeons was able to keep its identity, maintain its own special requirements, and demand special-

ized training of its members or fellows. In other words, here was continued the tradition which led directly to the present-day specialists.

thos

upp

and

thos

less

inci

sam

(an

vie

opp

The

coll

thei

ciet

nar

inn

phr

as

Son

mo

scie

true

Oth

to

selv

Suc

dra

tion

mic

19t

Lea

ply

fere

tion

cat

stil

Fel

Thus by the middle of the nineteenth century the modern framework of medical practice was quite apparent. The subsequent course is intimately tied up with the development of medical science, which by the last third of the century was growing in geometric progression.

As scientific data multiplied, medical practice became more complex. Practitioners tended to devote themselves to progressively narrower fields until now, in the middle of the twentieth century, specialism is indeed extreme. Nevertheless there remains the same overall pattern that existed two or even three centuries ago.

#### Societies and status

There are those practitioners who have devoted to their profession a very long period of study, and have acquired a profound knowledge. Others have had much less formal training, and their knowledge does not have comparable depth. A stratification is thus set up, based on type of educational training. There is an all too widespread evaluation:

those with long training form an upper group, enjoying high status and enhanced public esteem: those with lesser training receive lesser esteem, lesser status, and incidentally lesser fees. At the same time the different groups (and their sub-groups, if any) vie with each other for position, opportunity, privileges, They organize into tightly-knit colleges or societies to achieve their ends. All too often such societies may be controlled by a narrow, self-seeking, reactionary inner circle that utters pious phrases about the public welfare, as a cloak for selfish motives. Sometimes the leading figures are motivated by humanitarian and scientific interests, and exhibit a true statesman-like character. Other times they try principally to secure a monopoly for themselves and shut out competition. Such propositions as the above, drawn from historical observations, are just as applicable in the mid-twentieth century as in the 19th or 18th, or even the 17th.

**Learned profession** 

Although these principles apply generally, many obvious differences also apply. I would mention but two. One concerns education. Although today there still exists a vague admiration for the "learned" man, the physician who has a sound "liberal" education, such admiration is essentially lip-service only. This is one change which two centuries have wrought.

There is no need to elaborate here the defective general education of medical students. Despite many platitudes by many medical school deans, such education is not considered important. If it were, the schools would require it before granting an advanced degree, just as, years ago, Oxford required a master's degree in arts, before the candidate could study medicine.

Medicine is no longer a learned profession in the sense formerly understood. Gaining admission to medical school requires a long training, but this is usually a matter of precise technical education, not of so-called liberal studies.

This fact, the decline of general education among physicians, is closely connected with the change in scientific knowledge. A tremendous gap separates Williams Cullen from William Osler. To get from one to the other required a long transitional period, most sharply manifested perhaps, in the second quarter of the nineteenth century. There was a great change in the content and methods of medicine. There de-

hysician

ers or

ere was

ich led

y spe-

of the

nodern

ractice

e sub-

ly tied

f medi-

ne last

rowing

tiplied,

more

ided to

ressive-

low, in

th cen-

ed ex-

re re-

pattem

three

tioners

profes-

study.

ofound

e had

g, and

t have

atifica-

on type

here is

uation:

veloped precise measurements and quantitative observations which transformed medical practice and medical theory and which effectively disposed of the older physician.

Just as the Israelites after leaving Egypt had to wander for forty years in the wilderness before entering the Promised Land, so did the physicians, leaving the eighteenth century modes of thought, have to wander for a generation before they could enter the new land of scientific

promise. This transition was indeed quite painful, but was successfully made.

However, having made the transition, physicians are still not in Utopia. They face problems which, though differing in content from what their predecessors faced, are nevertheless strictly analogous in form.

The wise physician is one who can learn from past experience—and in meeting present-day problems avoid the mistakes of the past.



Febr

# Guest Editorial

#### Graduate Education in a Tax-Supported Hospital

When the prospective intern or resident is asked, "Why are you choosing a tax-supported hospital for your graduate education?" he will often reply, "Because there I shall have large numbers of 'staff patients' to work with and shall be delegated a lot of responsibility." This attitude has become increasingly prevalent in recent years, because the numbers of medically indigent patients admitted to the voluntary hospital have decreased as economic conditions have changed and plans have developed for insuring against the cost of hospital and medical care. In some cases, this decrease has been a matter of serious concern.

However, the recent medical graduate does not always realize that in a program of graduate education there are other important features beside the numbers of "staff patients" and the responsibility of their care.

Equally important, if not more so, is the professional staff under whose influence the intern and resident will come.

The physicians on the professional staff of a hospital are responsible for the learning environment of the

s suc-

e the ill not oblems ontent essors strictly

e who ence probof the

ysician

intern and resident. As preceptors, they should be interested in teaching and must have the time to devote to the education of the house staff. This is a time-consuming responsibility. An excellent, academically oriented staff may be so busy with its private work or other affairs that they have little time for the house staff and cannot contribute as much as might be expected to the educational process in a hospital or to the intellectual development of young physicians. The tax-supported hos-



F. A. SIMEONE, M.D. Director of Surgery Cleveland Metropolitan Gen. Hosp. Professor of Surgery Western Reserve Univ.

physicians. The tax-supported hospital has often had difficulty maintaining a professional staff which could devote a major portion of their time to teaching within the hospital. This problem of teaching-staff has more than offset the important advantages of relatively large numbers of "staff patients." However, recent developments have clearly demonstrated that a tax-supported institution can attract a strong full-time staff which together with an enthusiastic part-time staff can provide a very superior educational environment. Thus interns and residents are exposed not only to good clinical care of the sick, but also to teaching and research.

Experience with investigation should be an essential part of any residency program. Thereby the resident comes to appreciate the difficulties and the problems which beset the investigator. He learns that Nature has a tendency to guard her secrets jealously. Each clinical problem is a natural experiment in pathologic physiology.

The same approach is used to find the cause of the patient's disease. He learns to evaluate data and to

appraise the significance of the conclusions drawn by others on the basis of the evidence presented in support of those conclusions. When he concludes his period of residency, he will have made a start in the direction of avoiding empiricism and of treating his patients as a scientist as well as a physician. In addition, he will have made a start toward becoming an effective teacher himself.

It is reasonable to question the value of laboratories and of people doing research in the educational environment of the intern and resident. But even casual consideration makes clear the importance of a close relationship. The knowledge that within the same walls there are people discovering new, previously unknown facts about disease serves as a stimulus for the house staff to strive toward self-education. The programs of research attract brilliant, or at least interesting, men and women who in turn excite their younger colleagues on the house staff in investigative problems. The patient shares in the benefits of research. The knowledge is promptly applied, and in the course of applying it, the resident has intimate contact with specialists in certain fields.

The strength of a hospital in terms of the care of patients and the graduate or undergraduate education of young men and women is primarily determined by its staff. Physical facilities help the operation of any program in a hospital, but the inanimate structure is not really a part of the institution's personality. This is molded through the years by the men and women who are engaged in that all-important occupation of caring for patients within its walls.

That men and women of the highest quality and ideals, with interests in the care of patients, teaching, and research can be attracted to work both full-time

sician

and part-time in a tax-supported institution is now a demonstrated fact. Institutions similar to our own will undoubtedly develop in a comparable manner. Young graduates in medicine will find there an opportunity for acquiring experience in the care of the sick and injured and the opportunity for unlimited intellectual development.



CI

Cli

ma pit Ho con we ho in

the

bla

Fe

## Clinico–Pathological Conference

Cleveland Metropolitan General Hospital

#### Clinical abstract

H.A., a 48-year-old colored male, was admitted to City Hospital (now Cleveland General Hospital) on 22 September, 1953 complaining of weakness of three weeks' duration associated with hoarseness of voice and difficulty in swallowing solid foods.

Two weeks prior to admission the patient noticed the onset of cough productive of "white and black" sputum. He was seen by a doctor at the place of his employment and was given an injection of penicillin and some pills. His general condition continued to deteriorate. The patient lost 27 pounds in three weeks.

He was referred to County Clinic for chest x-ray examination and was admitted to the hospital on the same day as an emergency.

The patient was born in Norfolk, Virginia, and had worked on a farm. He came to Cleveland in 1933 and worked as a paper

The late Doctor Roy W. Scott, Professor of Clinical Medicine, Western Reserve University, 1929-1957, and Director of the Department of Medicine at Cleveland General Hospital until his untimely death, was a recognized master of "C-P-C-manship." The present case was one of his last and hitherto unpublished conferences which was recorded at the time of delivery.

- EDITOR: Dr. Thomas D. Kinney, Professor of Pathology, Western Reserve University, School of Medicine
- CLINICAL DISCUSSION: Dr. Roy W. Scott, Professor of Clinical Medicine, Western Reserve University, School of Medicine
- DISCUSSION OF ANATOMIC FINDINGS: Dr. K. Y. Lin, Demonstrator in Pathology, Western Reserve University, School of Medicine

and junk seller, a car washer, and as a window washer. For the past two years he had worked in the paint department of the Cleveland Transit System.

#### Physical examination

The patient appeared acutely ill and lethargic. He was well developed but poorly nourished. The temperature was 36°C... pulse 120, respirations 36, blood pressure 96/60, vital capacity 2.41 (61%), expiration time 5 seconds. Breathing was rapid and shallow. Questionable E to A changes and diminished breath sounds were found at the right apex posteriorly. No rales were present. The heart rate was rapid but regular. The pulmonic second sound equaled the aortic second sound.

No murmurs were heard.

The liver was questionably palpable.

#### Laboratory examinations

my

we

Iso

Cle

of

lun

Cu

cle

ger ne:

spi

ne

arc

co

dy

tin

wa

tio

sm

to

10

str

M

po

cil

in

N

11

cli

pl

pa

Fe

The urine had a specific gravity of 1.010, the albumin and sugar tests were negative, and there were a few white and red blood cells and epithelial casts per high power field. The blood hemoglobin was 8 grams, white blood cell count 15,000. Blood urea nitrogen 27 mg.%, sugar 97 mg.% and CO<sub>2</sub> combining power 36, 58, 52 vol.%.

X-ray of the chest showed a fine uniform mottling distributed evenly throughout both lung fields. Laryngeal examination revealed diffuse reddening, but no clear evidence of any specific disease, although the left vocal cord was not well visualized.

#### **Hospital** course

The patient was given 1500 cc of glucose and saline with vitamin supplements intravenously on the night of admission. Strepto-

mycin 1.0 gm. per day, plus PAS were started on 9-23-53 and Isoniazid 150 mg. twice a day was added the following day. Clear spinal fluid with a pressure of 108 mm. H<sub>2</sub>O was obtained by lumbar puncture on 9-24-53. Cultures were negative for tubercle bacilli as well as for other organisms. On 9-25-53 nasal oxygen was started because of shortness of breath. Blood streaked sputum was noticed during the next several days.

ravity

sugar

there

blood

high

emo-

blood

urea

97

ower

red a

outed

lung

n re-

it no

ecific

vocal

00 cc

vita-

ly on

epto-

temperature fluctuated The around 38°C. throughout the month of October. The patient continued to be lethargic and dyspneic, requiring oxygen at times. Occasionally the patient was confused and had hallucinations. His cough persisted with small amounts of mucoid expectoration. PPD first strength on 10-4-53 was negative. Second strength PPD test was not done. Many sputum cultures were reported negative for tubercle bacilli.

There was slight improvement in his general condition during November. Lumbar puncture on 11-14-53 was again negative, including culture for tubercle bacilli.

On 12-21-53 the patient complained of right upper quadrant pain. Examination showed the liver to be enlarged to 5-6 fingers below the costal margin. The tip of the spleen was also palpable.

The following liver function tests were done: Cholesterol and esters 88/41; cephalin flocculation 2 plus at 24 hours; BSP 24, thymol turbidity 14 units; serum albumin 3.2, globulin 3.8, ratio 0.85. One blood culture was negative. Routine febrile agglutinins on 12-21-53 were positive to proteus OX during the first week in November.

On January 7, 1954 the patient became confused, extremely lethargic and dyspneic. He died the same day.

#### Clinical discussion

DR. ROY W. SCOTT: It is clear from this protocol that we deal with a 48-year-old colored male who died about 4 months after the onset of illness. From a clinical standpoint, the patient ran a progressively downhill course, dominated by loss of weight, loss of strength, some lethargy, intermittent fever and anemia. Of course, these things can go with a lot of fatal diseases and don't help very much.

Now, he was admitted as an emergency after a two or three week history which is not contributory, in my opinion, to the diagnosis; the major thing is that

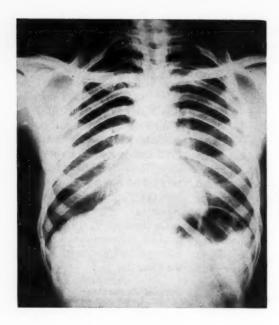


Fig. 1 Nodular infiltration of lung at time of admission.

he had lost 27 pounds in 3 weeks. He went to the County Clinic where an x-ray examination of his lungs was made and he was rushed to our hospital as an emergency. In all probability, from the treatment instituted, it was assumed that this man had tuberculosis.

Now the temperature at the time of admission was not elevated, but the pulse was, and respirations were three times normal. He had significant diminution of vital capacity, and the blood pressure was low. The liver, at the time of admission was barely palpable, but this increased in size while in the hospital until it was 4-5 fingers below the costal margin and apparently was tender because he complained of pain in the right upper quadrant.

He had anemia, Hb. 8 grams, and only one white count was done, which disturbs me. I wish there had been more for one is taking a great chance in putting too much emphasis on one high

Fig. infilmonth mission befor

white this. nitro of te clear inforserve the

for

look

Di

Febru

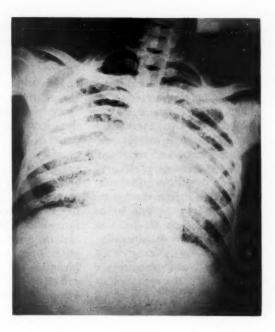


Fig. 2 Pulmonary infiltration three months following admission and two days before death.

ar in-

ng at

ion.

The

ssion

is in-

hos-

elow

ently

com-

apper

rams,

was

wish

ne is

atting

high

ysician

white count in a difficult case like this. Sugar, CO<sub>2</sub> and blood urea nitrogen were normal. The x-ray of the chest gives us the first clear, clean-cut bit of objective information, which I think, deserves further discussion as to the differential diagnosis.

I think at this point we might look at the x-rays and also ask for the roentgenologists' opinion.

#### Nodules

DR. SIMON SPENDIARIAN (Associate Radiologist, CMGH): The

roentgenogram of the chest made on admission shows uniformly distributed granular small nodular infiltration throughout both lung fields interpreted as miliary tuberculosis (Fig. 1.) The heart appears to be normal in size. The bony thorax is normal.

The next film was made on Oct. 22, 1953 and it is quite clear that there is an increase of nodularity throughout the lung fields and that the individual nodules appear a little larger than on the previous film. The next film was

February 1959, Vol. 5, No. 2

made on Dec. 29 and there is rather marked decrease in the size and numbers of the individual nodules throughout the lung fields (Fig. 2). The diaphragms and heart appear unchanged.

A film of the abdomen which was taken on Dec. 31 shows a homogenous haziness in the upper abdomen and there is a fairly large mass in the left upper quadrant as well as in the right upper quadrant interpreted as an enlarged liver and spleen. So the final diagnosis on the basis of radiological study is miliary tuberculosis, rapidly progressing, hepatomegaly and splenomegaly.

#### No tubercle bacillus

Dr. Roy Scott: The patient was treated as a case of tuberculosis. Various cultures taken; at no time was the tubercle bacillus found, either in cultures of sputa, spinal fluid or other body fluids. Now, the patient became confused and had hallucinations. In a man this ill and this near to death, that isn't too remarkable, particularly if he received some sedation. His cough, which he had earlier, persisted; the PPD first strength on the 4th of October was negative; a second apparently wasn't done. There was slight improvement in his general condition, in November, and a lumbar puncture was again negative. Around the first of the year the liver was enlarged 5-6 fingers below the costal margin and the tip of the spleen was also palpable. Here we have evidence from the tests done that there was some decrease in liver function. The blood cultures were negative.

He continued to have a fever and on Dec. 21 the routine febrile agglutinins to OX 19 were positive in a dilution of 1:640. Now that bothered me a little because that test, as you know, is reliable in the rickettsial disease, Rocky Mountain Spotted Fever, typhus and so on, but I don't know and I couldn't find out whether it is of any significance in tuberculosis.

As I said earlier, the most important feature in this case are the nodules in the lungs. There is no question about that—it is not subject to argument or debate—so that the problem is reduced to what causes the nodules in the lungs?

Of course, the very first thing one thinks about in lungs like these is miliary pulmonary tuberculosis because it is commonest. In Negro males with lungs like these you would be on very sound ground from a statistical standpoint in saying that this is miliary pulmonary tuberculosis. But

we ha

No miliar as a and hilar ple I sick with that w

sarco

He tion sort is and in tients togeth in chihole evide mitra dismi

Siliules is the li larger sick : Furth of ex know difficuthink cinon heim with phati these

Febru

we have no positive evidence of tuberculosis.

again

f the

5-6

argin

was

evi-

that

liver

were

fever

ebrile

posi-

Now

cause

liable

locky

phus

v and

is of

osis.

st im-

e are

ere is

is not

ate-

ed to

n the

thing

like

uber-

onest.

s like

sound

stand-

mili-

. But

vsician

Now, sarcoidosis may give miliary nodules in the lungs, but as a rule they are a little larger and one expects to find more hilar shadows. And then, the people I have seen haven't been this sick and haven't died so soon with a rapid downhill course, so that would make me feel it is not sarcoidosis.

Hemosiderosis is a rare condition to produce lesions of this sort in lungs, but it does occur and must be considered. Such patients with deposits in the lung, together with fibrosis, are usually in chronic failure from buttonhole mitral stenosis. We have no evidence that this patient had mitral stenosis. So I think we can dismiss hemosiderosis.

Silicosis causes miliary nodules in the lung. But here again, the liver and spleen are not enlarged and the patients are not as sick and don't die in 4 months. Further, there is usually a history of exposure to some substance known to contain silica. Another difficult problem, that we must think about, is lymphogenic carcinomatosis. I saw a case in Erdheim's Laboratory in Vienna, with terrific spread to the lymphatics producing nodules like these, which arose from a very

small carcinoma of the bronchus. It could, I suppose, involve the liver secondarily, but I have great difficulty explaining the big spleen in lymphocytic carcinomatosis. I have seen, in San Francisco, several cases of coccidiomycosis with lungs exactly like these. In California, as you know, the disease is endemic, but we have no evidence that this man was in this area and the disease is very rare in the East and Midwest. I don't believe this is coccidiomycosis.

Now, cases have been described, but I don't think I ever saw one, of miliary nodules in the lung in panarteritis. I've never seen a case in which nodular infiltration of the lungs is described. The lesions are usually larger and of course, the disease involves other systems, and we have nothing here. He could have an enlarged liver and spleen, of course with, panarteritis.

#### Histoplasmosis

Now, I have left for the last that which I think is the diagnosis in this case. I don't see how anybody could rule it out with the evidence at hand, namely, histoplasmosis. Why? Because it produces lesions which are widespread in the lungs which cannot be differentiated from miliary tuberculosis on the x-ray alone.

The organs involved in histoplasmosis, in the order of frequency, are 1) lymph nodes, 2) liver, 3) lungs, 4) spleen, 5) adrenals, 6) intestines, 7) bone marrow and 8) kidneys.

Here we have a big liver, a large spleen, certainly involvement of the lung, and the only thing out of line so far as I know is this one white count of 15,000. The vast majority of people with histoplasmosis have a leukopenia and may have anemia too, so that the white count of 15,000 bothers me a little; but as I said before, you can't put all your eggs in one single laboratory basket in a clinical diagnosis—I've burned my fingers many times by so doing.

#### Comment

Dr. THOMAS KINNEY: Dr. Robbins, would you comment on the case?

DR. FREDERICK ROBBINS: (Professor of Pediatrics, W.R. U.): I am inclined to agree with Dr. Scott. From Columbus north, histoplasmosis is rare, although in the South it is common. I believe it occurs in the area of Virginia from which this man came. I don't see a thing in this protocol which would allow you to rule out histoplasmosis, and

certainly the roentgenogram is compatible with the diagnosis. Dr. Scott pointed out that the white count is a little high, but one shouldn't take white counts too seriously, at least not a single one.

There are other diseases that might be considered that were mentioned. One of these is blastomycosis which is not often diagnosed. Only recently, since they have developed more specific tests, has the diagnosis of pulmonary blastomycosis been more commonly made. I have never had any experience with the clinical disease. Another disease I would like to ask if anybody knows anything about is aspergillosis, which is usually, as I understand it, the result of massive inhalation of aspergillus and usually occurs in debilitated people. Finally, there is a wonderful disease which occurs only in New England as far as I know. but I don't see why it couldn't occur here. It is called lycoperdonosis. The name is derived from the Latin name of the puffball, which is a mushroom, and which when mature are loaded with black spores. If you step on one it releases a cloud of the black spores. These patients develop a miliary type of pneumonia. I heard of it from Dr. Neuhauser

at Bo happ in M Ham custo order turn of re

Profe like to patie shou type ceive thera

Resp

have chen

Febru

lack



Fig. 3 Section of lung showing diffuse nodular infiltration.

at Boston Children's Hospital. It happens to be recognized mostly in Maine, Vermont and New Hampshire where they have the custom of sniffing puffballs in order to stop nose bleeds. This in turn may produce a nodular type of reaction in the lungs.

#### Response

nosis.
t the
, but
ounts

were s blaoften since spe-

sis of been

have

with

r dis-

any-

ut is

ly, as

It of

gillus

itated

won-

only

now.

aldn't

oper-

from

fball.

which

with

one

black

lop a

ia. I

auser

sician

DR. JOHN HARRIS (Assistant Professor of Medicine): I would like to ask—you hear it said that patients who have tuberculosis should respond clinically to the type of therapy this patient received. Is that a reasonably good therapeutic trial? Can you exclude tuberculosis by response or lack of response?

Dr. Scott: No, although we have been using response to chemotherapy as a diagnostic aid.

It will help but does not make the diagnosis, although lack of response should make you look further.

#### Pathology

DR. KINNEY: Dr. Lin will discuss the pathological findings.

DR. KU YIN LIN: This is a case of disseminated histoplasmosis involving the lungs, liver, bone marrow, spleen, kidneys, adrenals and mesenteric and tracheobronchial lymph nodes. The lungs were firm in consistency and heavy, the right lung weighing 1200 grams and the left lung 1100 grams. The pleural surfaces were mottled gray and dark blue and innumerable small yellow white nodules were visible beneath the visceral pleura. Simiwere distributed nodules

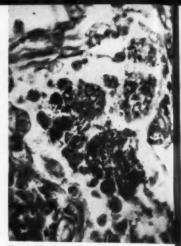
throughout all lobes of the lungs, with a somewhat heavier deposition in the left lung (Fig. 3). There was a single, irregular cavity measuring 1.5 x 2 cm. in the left lower lobe, with poorly defined friable walls.

On histological examination the nodules appeared as irregular areas of necrotic tissue surrounded by granulation tissue (Fig. 4).

Small yeast - like organisms, with the morphological characteristics of histoplasma capsulatum were seen within large mononuclear and reticuloendothelial cells (Fig. 5). The organisms were round to ovoid with a refractile membrane and measured 3-5 microns in diameter.

The liver was enlarged and weighed 2000 grams. There was moderate hyperemia. Multiple granulomatous nodules were present throughout the liver and in addition many of the Kupffer cells contained histoplasma. The spleen was twice the average size and weighed 375 grams.

Numerous nodules containing histoplasma were scattered throughout the parenchyma. Similar nodules were found in the kidneys, adrenals and mesenteric and tracheobronchial lymph nodes. Large mononuclear cells in the sinuses of the bone marrow



conta

stains

for tu

Ende

In

the 1

chop

chron

acute

mon

locat

regio

ies l

be i

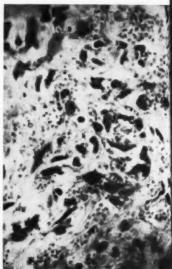
Miss

basi

arou

A

Fig. 4 (Top) Photomicrograph illustrating structure of pulmonary nodule. Fig. 5 (Bottom) High power magnification of nodule demonstrating presence of Histoplasma Capsulatum in large mononuclear cells.



contained histoplasma. Acid fast stains of all lesions were negative for tubercle bacilli.

#### Endemic

Fig.

ion of

Histo-

uclear

ician

In addition to these findings the patient had extensive bronchopneumonia in all lobes; chronic pulmonary emphysema; acute tracheobronchitis; and pulmonary edema.

As is well known, Cleveland is located at the periphery of a region in which epidemiologic studies have shown histoplasmosis to be endemic, that is, the lower Mississippi and Ohio River basins. This patient lived in and around this region for many years

and so had ample opportunity to contact the disease.

There was a close correlation between the clinical signs and symptoms and the lesions found at postmortem examination. The roentgenogram of the lung and the pulmonary signs and symptoms were due to the nodular character of the granulomatous lesions caused by the histoplasma and to the superimposed bronchopneumonia and pulmonary edema. The enlarged liver, spleen and lymph nodes were also directly attributable to the histoplasma and the anemia was presumably due to the involvement of the marrow by the histoplasma.



"Fault! Dr. Gordon is over his side of the midline."

# Cleveland Metropolitan General Hospital



In 1837, Cleveland, Ohio, was struck with an epidemic of cholera. To house the overflow of sick and dying, the city acquired a small wooden structure, provided beds and medicine. The epidemic over, the building was converted to the city poorhouse and later became City Hospital.

From these beginnings stemmed the present Cleveland General Hospital with 17 buildings on 27 acres on Cleveland's West Side, about 15 minutes from the downtown area.

Today the hospital provides service in general medicine, surgery and their subspecialties, as well as pediatrics, obstetrics, tuberculosis and contagious diseases.

Febr



#### One of a series on leading medical centers,

CMGH does not operate a psychiatric unit, relying on a state operated facility located on the grounds.

In order to provide a broader base of tax support, and more efficient administration of health facilities for an expanded community, the hospital was transferred from city to county operation early last year. Currently the hospital's 894 beds and 50 bassinets serve the 1,600,000 citizens of Cuyahoga County. During 1957, 9981 patients were admitted to the hospital and 3218 babies were born. Ambulatory service was provided as follows: Outpatient Clinics, 96,210; E. 35th St. Dispensary (Pediatric), 24,316; Emergency Room, 23,576, and total visits of 144,102.

ysician

Membrane oxygenator in use at CMGH where it was developed.



The first regular professional staff of 28 physicians and surgeons was named in 1891, as well as a number of interns required to serve 18 month appointments. Control of all medical staff appointments by Western Reserve University School of Medicine was initiated in 1913. A Citizen's Committee assumed an advisory role in 1928, and with the transfer to the County, the hospital acquired a Board of Trustees and now has complete, independent operating authority.

The attending staff numbers 50 full-time physicians, 35 part-time salaried physicians, and 200 physicians with outside practice who volunteer their services. All are members of the University faculty.

#### Physical facilities

90

Separate buildings house the general hospital, contagious unit,

pathology department, tuberculosis hospital, outpatient clinics, house officers' quarters and the administration building, the nurses' quarters, and the emergency and research unit. (The latter, completed in 1956, includes 17 separate units and a metabolism ward housing 12 patients.)

House officers and medical students participate regularly in research activities under the guidance of full-time directors. The facilities are often used for detailed and correlative studies which determine the diagnosis and management of patients housed in the general hospital. Additional research projects are carried on in the Pathology building.

A five-story outpatient unit now under construction to replace the present outmoded building will be ready for occu-

Resident Physician

pand the clini depa room ices. prog addi



pancy early in 1960. It will house the 35 general and specialty clinics along with a new x-ray department, pharmacy, record room, and other ancillary services. This particular building program will make available additional professional offices,

rcu-

lin-

and

the

ner-

The

in-

d a

reuid-

The

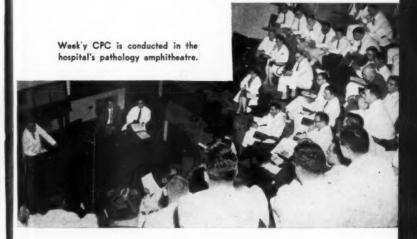
dedies nosis ents ital. are

unit reoded ccu-

ician

laboratory facilities, conference rooms, and libraries in Lowman Memorial Pavilion, the tuberculosis hospital. At the same time the admitting and emergency area will be remodeled.

The hospital has enjoyed a very close relationship with West-



February 1959, Vol. 5, No. 2



Wyeth brings you 2 delicious liquid forms of penicillin V potassium.

blood

peak

For Liqu tenc ible

is it

trea

to

SOF

ass

act

liq

tas

fla



Conforms to Code for Advertising

HIGH POTENCY (peach-flavored) 250 mg. (400,000 units) per 5-cc. teaspoonful: golden color

Supplied: Combination package of vial of dry powder and 1 bottle of diluent to make 40 cc.

MEDIUM POTENCY (raspberry-flavored) 125 mg. (200,000 units) per 5-cc. teaspoonful; raspberry color

Supplied: Vial of powder to be reconstituted with water to make 40 cc.



Philadelphia 1, Pa.

Of

blood levels in 15 minutes ... beak levels in 30 minutes



For taste-fussy patients of all ages, Liquid PEN. VEE K gives you two potencies and two fruit flavors for flexible, patient-accepted management. It is indicated for both prophylaxis and treatment in all infections responding to oral penicillin. Ready, reliable absorption and rapid, high blood levels assure clinically effective therapeutic action. Liquid PEN. VEE K is the only liquid preparation of penicillin V potassium in two strengths and two flavors.



onful:

of dry 40 cc.

vored onful:

tuted

#### Conferences, Clinics and

#### MONDAY

- 8:30 Autopsy Gross Conference9 Medical Visitants' Rounds
  - 10 Pulmonary Diseases Morning Staff Conference
- 10:30 Surgical Pathology Slide Conference
  - 11 Contagious Diseases Visitants' Rounds
- 11:30 Lowman Pathology Gross Conference
  - Obstetrical Manikin Session (bi-weekly)
  - 4 Obstetrical Rounds
    4:30 Medical Rounds
    - 5 X-Ray Conference

#### TUESDAY

- 8 Orthopedic Grand Rounds 8:30 Pulmonary Diseases Bron
  - choscopy Session

    9 Medical Visitants' Rounds
  - 10 Pulmonary Diseases Morning Staff Conference
- 10:30 Surgical Pathology Slide Conference
  - II Pediatric Visitants' Rounds
  - II Gynecology Special Clinic
  - Hematology Metabolism Conferences (alternate weeks)
- 12:30 Tumor Conference
  - Pulmonary Diseases Orthopedic Conference (alternate weeks)
- 1:30 Medical-Surgical Chest Conference (alternate weeks)
  - 2 Interns Pediatric Lecture Course
  - 4 Pediatric Pathology Con-

ference (1st & 3rd Tuesdays)

Rot

11

10:3

12:3

1:3

FRII

9:

10:

12

577

F

5 Surgical Service Meeting 6:30 General Staff Dinner Meeting (4th Tues. of Month, Oct. thru May)

#### WEDNESDAY

- 8:15 Contagious Diseases Rehabilitation Conference
- 8:30 Autopsy Gross Conference 9 Medical Visitants' Rounds
- 9:15 Pediatric Psychiatric Con-
- ference 10:30 Surgical Pathology Slide
- Conference
  11 Pediatrics & Contagious
  - Diseases Grand Rounds

    11 Obstetrical Special Clinic
  - II Combined Medical Surgical Grand Rounds
    - Obstetrical Gynecology
      Grand Rounds
  - 1:30 Pulmonary Diseases Pediatric Conference
  - 1:30 Special Pediatric Clinic 2:30 Obstetrical - Gynecology
  - Pathology Conference
    4 Chest Disease Lecture
    - Chest Disease Lecture
       Series (alternate Wednesdays)
  - 4:30 Medical Rounds
    - 5 Basic Science Lectures (Winter and Spring only)
- 7:30 Pulmonary Diseases Re-Expansion Conference (County-wide)

#### THURSDAY

8 Neurosurgical Service

and

Tues-

eting inner s. of lay)

Rence erence ounds Con-

Slide agious ads

Clinic Surgicology

Pedinic cology e ecture

dnes-

ctures only) Re-

rvice

Rounds

Meeting (last Thursday)
10 Pulmonary Diseases Morning Staff Conference

10:30 Surgical Pathology Slide Conference

11 Contagious Diseases Visitants' Rounds 12:30 Gastrointestinal Confer-

ence
1:30 Medical - Surgical Chest
Conference (alt. weeks at

Sunny Acres)
3 Pediatric X-Ray Confer-

4 Infectious Diseases Rounds (Peds. & Contag., 1st Thursday)

4:30 Pediatrics and Contagious Diseases Tea-Conference

FRIDAY

8:30 Surgical Pathology Slide Conference

9 Medical Visitants' Rounds 9:30 Pediatric Psychiatry Conference

10:30 Autopsy Gross Conference

11 Pediatric Visitants' Rounds 12:30 Clinical-Pathological Conference

1:30 Autopsy Slide Conference 1:45 Medical-Surgical Cardio-

vascular Conference
2:30 Pulmonary Diseases Surgi-

cal Preview Conference
3:30 Thoracic Surgical Service
Meeting

4 Gynecology Rounds

4:30 Medical Rounds

ern Reserve University Medical School for many years. Cleveland General Hospital, along with Lakeside and Crile Veterans Hospitals, serves as a primary teaching unit for the University's medical students. Beginning in 1950, a full-time staff was added to the already excellent part-time staff; as a result, participation in teaching within the University was extended into the preclinical levels. The University, through research grants and endowments, contribapproximately \$600,000 utes vearly to the function of this teaching unit.

#### Teaching

In addition to its extensive house officer training program, the hospital is actively engaged in the teaching of medical students beginning with the freshman year. Medical students serve four months on a basic clerkship on either the adult or children's service. Additional clerkships for students are assigned in other departments. Students also work in the specialty areas and in research on an elective basis.

The School of Nursing is affiliated with the Frances Payne Bolton School of Nursing at Western Reserve. Student nurse affiliates from many hospitals receive training in nursing specialties

lacking in their own hospitals. The hospital also maintains schools for medical technologists and for x-ray technicians, and trains practical nurses, dietary assistants, medical social service workers and hospital administrators.

#### House staff

Cleveland General Hospital offers 16 rotating internships and 10 straight internships (4 in internal medicine, 4 in general surgery, and 2 in pediatrics and contagious diseases). The rotating internship uniformly provides the following schedule:

Medicine 3 months Surgery 3 months Pediatrics & Con-

tagious Diseases 3 months
Obstetrics &

Gynecology 2 months Emergency Room 1 month

Residency posts beyond the intern level number approximately one hundred.

Almost all patients admitted to the hospital are ward patients; their treatment is primarily the responsibility of the visiting staff which delegates to the house staff as much responsibility as they can accept. Private patients are also admitted with the understanding that they will be available for house staff and student training. From resident-intern stipends, county regulations require a monthly deduction of \$45 to cover room, board, and laundry. The hospital provides uniforms for all members of the house staff, and full laundry service for uniforms and personal items. By means of a credit union, a loan fund has been established by the medical staff for members of the house staff who may need financial assistance.

#### Housing and meals

All members of the house staff are accommodated on the hospital grounds. Apartments for wives and children are available in the immediate neighborhood, as well as in low-cost housing developments, from which public transportation provides easy access to the hospital. Seven different low-income public housing units are operated by the Cleveland Metropolitan Housing Authority. The size of the family determines the size of the dwelling assigned. Rent is approximately 20 percent of the lessee's income. Rent includes heat, electricity for light and refrigeration, hot and cold water, and gas for cooking. Dwellings are equipped with gas range and electric refrigerator. Each unit has a private bath and ample closet space to dry.
rms
buse
for
By
loan
the

nan-

staff hosfor ilable nood, g deoublic y aclifferusing Cleve-Auamily dwellproxiessee's , elecration, as for ipped

hysician

a prispace

Derr Sy nte Neu Obs G Option Patil hy ulr Sure Tho Uro Der

#### CLEVELAND GENERAL HOSPITAL APPROVED RESIDENCIES

ERVICE	CHIEF OF SERVICE	YEARS LENGTH OF RESIDENCY	PREREQUISITE
Anesthesiology	H. E. Kretchmer	2	Internship
Dermatology & Syphilology	Ruth Rauschkolb	3	Internship
nternal Medicine	Charles H. Rammel- kamp, Jr.	3	Internship
Veurosurgery	Byron M. Bloor	5	I yr. gen. surg.
Obstetrics & Gynecology	Alwyn E. Bennett	4	Internship
Ophthalmology	Russell J. Nicholl	3	Internship
Orthopedic Surgery	F. W. Rhinelander	3	I yr. gen. surg.
Otolaryngology	S. C. Missal	2	Internship
athology	T. D. Kinney	4	Internship
ediatrics & Con- tagious Diseases	F. C. Robbins	3	Internship
hysical Medicine	Nadene Coyne	3	Internship
ulmonary Diseases	R. C. McKay	2	Internship
Radiology	Harry Hauser	3	Internship
urgery	F. A. Simeone	4	Internship
horacic Surgery	G.H.A. Clowes, Jr.	5	3 yrs. gen. surg.
Jrology	Harry R. Trattner	4	I yr. gen. surg.
Dental Surgery	A. J. Tomaro	1	Dental Intern-



An active premature infant suite at CMGH with accommodations for 22 newborn.

in addition to living room, kitchen, and bedrooms.

Dependents of the house staff are permitted to use employee meal tickets (\$1.10 for three meals).

#### **Employment for wives**

The hospital welcomes wives of residents seeking employment—as technicians, nurses, clerks, secretaries, x-ray technicians, dietitians, social service workers, and OT and PT therapists.

The City of Cleveland with its many varied industries, large department stores and hundreds of business offices, offers many opportunities for employment as receptionists, bookkeepers, secretaries, sales personnel and like positions.

The Harold H. Brittingham Memorial Library was established in 1938, and is housed in the main administration building, conveniently located to the house officers' quarters. After the Allen Memorial Library of the Cleveland Academy of Medicine, Brittingham is the largest and most attended library facility in the city. Currently it has more than 8,000 volumes and subscribes regularly to 159 medical and scientific journals. Books and journals not available in the library can be obtained on loan from the Allen Memorial Library through the hospital librarian.

The library's facilities are available 24 hours daily throughout the week to the entire professional staff of the hospital.

Rec

persium in dor hou and locaresi offi

dia Me sys wit

floo

"Jo

#### **Recreational facilities**

ore-

suite

ac-

for

am

ned

the

ng, use len ve-

rit-

ost the an oes nd nd lian

re ho-

an

Four hard-surfaced tennis courts are available to hospital personnel. A basketball gymnasium and a swimming pool located in the basement of the nurses dormitory are available to the house officers. A handball court and a large recreation room are located in the basement of the residents' quarters. The house officers' lounge is on the first floor of the quarters.

Sandlot softball and hardball diamonds, a part of the Cleveland Metropolitan Park Recreation system, are conveniently located within 10 minutes drive of the hospital. All house officers and

their families are also welcome to join a new and large YMCA less than a mile from the hospital.

#### Religious services

Cleveland Metropolitan is a non-sectarian institution, admitting patients of all faiths. But many patients who come to the hospital with physical problems are also in need of spiritual comfort and guidance. This need is met by chaplains of all faiths who visit the hospital daily, and who are on call 24 hours a day for emergencies. Protestant and Catholic Church services are held at the hospital for patients and hospital personnel.



## ODSTETRICS:

# TARGET FOR MALPRACTICE

George A. Friedman, M.D., LL.M.

A large number of lawsuits are brought against physicians specializing in obstetrics and gynecology. That this should be so is not surprising. In pregnancy and childbirth cases there is a considerable likelihood of some unfortunate results, even with the best of care.

Many of the cases are concerned therefore with the issue of proximate cause, that is, with the necessity of proving clearly that the injuries resulted from the medical treatment and not as a natural consequence of the patient's condition or from some other cause.

Some other significant cases which have arisen in this field and which will be discussed in this article are those involving diagnosis, use of unsterile instruments, failure of attendance, post-operative treatment, injury to infant, rights of unborn children, abortion, damages, liability of hospitals and statute of limitations.

#### Proximate cause

Some of the more frequent malpractice cases arising from negligence in pregnancy or child-birth treatments which have centered upon the issue of proximate cause are those in which plaintiffs allege failure of attendance, development of infection, failure to remove placenta or other injuries to the mother or child.

Most cases in which plaintiffs have relied upon the physician's failure to give prompt and proper in I case and the first critision ing. hyp

atten

cessf

in do for ch ve sid pi

bl

of

pea

d ly

1

attendance and care are unsuccessful. A case in point occurred in Kentucky in 1941. In that case the mother had eclampsia and died shortly after delivery of the child. When the physician first arrived he knew she was in critical condition due to convulsions which she was then suffering. He administered morphine hypodermically, and then 2 c.c.'s of magnesium sulphate intramuscularly when the convulsion repeated.

He called in a consultant, and in the course of  $2\frac{1}{2}$  hours the doctors delivered the baby with forceps, meanwhile administering chloroform to the patient to prevent recurrence of the convulsions. After the delivery  $\frac{1}{2}$  c.c. pituitary was given to control bleeding and regulate contraction of the uterus.

The physicians remained an additional 45 minutes and then departed. The mother died shortly thereafter.

t

The physician was not held liable. The consultant testified that the patient died of toxic poisoning, that a heart stimulant was administered before they departed which could not be repeated within three or four hours and that nothing more could have been done had they remained. The plaintiff failed to establish

that the physician's actions in leaving patient had in any way contributed to her death.<sup>1</sup>

#### Infection

The difficulty of tracing the cause and source of an infection dooms to failure, similarly, most cases in which plaintiff alleges her infected condition was the result of defendant's negligence.

A 1929 Alabama case is in point: Plaintiff claimed she suffered from blood poisoning as a result of defendant physician's failure to wear gloves in packing plaintiff's vagina after a miscarriage. Defendant claimed the blood poisoning existed prior to the miscarriage.

Defendant brought out that plaintiff had been sick almost a week before he was called, had taken douches and treated herself despite her knowledge gained from two prior miscarriages. The court held that no causal connection between the alleged negligence and injury was proved. It said:

"Proof which goes no further than to show that the injury could have occurred in the way alleged does not warrant the conclusion that it did so occur, when the proof of injury can with equal probability, be attributed to some other cause."<sup>2</sup> Anderson v. Stump, however, was, to the jury, a clear case of negligence plus proximate cause. Defendant physician testified that the patient, a pregnant woman, was peculiarly susceptible to infection at the time when he examined her. He further testified that he did not know whether the glove he used in the examination had been sterilized or not, since he got it from the nurse.

Plaintiff testified that the examination was made by the doctor in his street clothes and without a glove. The jury concluded that the infection which subsequently developed in plaintiff's vagina was the result of defendant's lack of care.<sup>3</sup>

#### Hard to prove

Those cases in which plaintiff claimed that defendant's failure to insure that all the placenta had been expelled from the womb after childbirth resulted in infection are similarly difficult to prove. Defendant physician delivered plaintiff of a child but failed to remove a part of the placenta from her uterus after the birth. Plaintiff subsequently developed septicemia.

At the trial another physician who treated plaintiff after delivery testified that defendant's failure to remove part of the placenta might have caused the infection. He further testified, however, that plaintiff was suffering from pyorrhea and that she was in a rundown and weakened condition. Septicemia might have been caused by pyorrhea or latent germs in the genital tract during her weakened condition.

The court's finding was in favor of the defendant. There was no degree of certainty whatever that any negligence of the defendant caused her sickness.<sup>4</sup>

It is most often a question for the jury whether the act or omission of the physician was the cause of the injury sustained. Defendant admitted to plaintiff that the burns she suffered following childbirth were due to negligence in the delivery room in that she had been overexposed to a disinfectant solution which had been applied to her prior to the delivery of her child.

bi

is

At the trial, experts testified that the burns were due to friction and pressure or to a combination of shock and pressure, to the fact of labor debilitating the burned area, and possible but unlikely augmentation of the foregoing causes by the treating of the burned area with a disinfectant solution.

It was held that it was for the jury to decide the cause of the



burns.<sup>5</sup> While expert testimony is essential, it cannot usurp the function of the jury.

#### Diagnosis

the fied.

suf-

she

ned

lave

tent

ring

in

was

ver

nd-

for

nis-

the

De-

hat

ing

ice

he

is-

en iv-

ed

ic-

n-

e,

ng

ut

ne

ng

n-

ie

ie

An incorrect diagnosis does not by itself prove negligence. The patient must show that the physician failed to exercise average skill and learning, and use ordinary care in his treatment, and that this failure was directly responsible for the injury complained of.

A 40-year-old patient exhibited the conventional symptoms of early pregnancy—cessation of menstruation, excessive vomiting, etc. The two physicians whom she consulted suspected either menopause or pregnancy.

At the end of the three-month

period the patient visited the defendant-physician, told him she had visited another physician, and asked whether she was pregnant. He did not inquire about the diagnosis of the other physician, but insisted upon an x-ray and operation for gall bladder trouble.

As soon as the surgeon made his incision he discovered that the patient was pregnant and that the gall bladder was affected no more than is usual in cases of pregnancy. The patient recovered from the operation and was delivered of a normal baby at the end of the usual period of gestation. The court held that these facts were enough to submit to the jury to decide whether the physician used due care and diligence in making his diagnosis and in the treatment that followed.

#### No evidence

In another case, the patient sued the physician for failing to discover her pregnancy during the operation for the removal of a tumor of the cervix and during his post-operative treatment. She later gave birth to a dead baby and claimed at the trial that it was killed by the physician's probing with a metal instrument during the post-operative treatment.

The court held that there was no evidence as to how the child died. As for the failure to diagnose the pregnancy, the court said:

". . . It does not appear that if he had known the fact, his treatment of her would have been different from what it was. It was necessary . . . to remove the tumor, whether the respondent was pregnant or not; and that the [physician] performed the operation skillfully and successfully the evidence shows beyond any question."

#### No examination

A specialist is entitled to rely on the diagnosis of another physician and treat patient accordingly without making an independent examination and diagnosis. Plaintiff's family physician diagnosed her case as tumor. He thereupon took her to defendant, an x-ray specialist, for treatment.

While defendant gave plaintiff a slight examination by feeling the abdomen which tended to confirm the family physician's diagnosis, he relied primarly on the diagnosis of the family physician. The court held this was a proper reliance, particularly in the absence of anything warranting a contrary conclusion.<sup>8</sup>

The physician's duty to the pa-

tient does not end after delivery. He must be available or provide a substitute to treat any post-partum complications that may arise. Thus, the physician may have to treat an infected breast, or remove placental fragments.

#### Postoperative

Defendants performed the operation of conization of the cervix upon plaintiff. They then inserted gauze for a period after the operation, removed it and took no other action. The cervix grew together necessitating additional treatment and ultimately the removal of plaintiff's uterus.

It was held that defendants failed to follow good medical practice in taking steps to insure that the uterus remained open.<sup>9</sup>

Plaintiff, an unmarried woman, was three months pregnant. When she went to defendant for treatment, she was apparently very ill and in great pain. Defendant brought her to a hospital where he told the authorities he believed she' had a miscarriage. The hospital was unable to receive her, but defendant was advised to go to another hospital.

Instead he returned with plaintiff to his office, stayed there with her a few hours, administering no treatment save to give her a little water. When she became uncondone and W morn

sciou

caus hem abou The

nan

1

not ope of car jus res

> aft in de ne su

tre

er or

scious, he felt nothing could be done for her so he left her there and went home.

verv.

vide

ost-

may

may

east.

op-

rvix

rted

op-

no

rew

nal

re-

ints

ical

ure

n.9

an,

nt.

for

tlv

)e-

tal

he

ge.

re-

d-

al.

n-

th

10

le

n-

n

S.

When he returned the next morning, he found her dead. A postmortem disclosed that the cause of her death was peritonitis, hemorrhage and shock brought about by a rupture of her uterus. The rupture was due to instrumental interference with pregnancy.

The court said that whether or not defendant had performed the operation on her, he was guilty of the grossest negligence in the care given and the jury was well justified in finding that her death resulted as a consequence of his negligence.

She had sought professional treatment from him immediately after the operation and remained in his care thereafter until her death. It was his duty to take all necessary steps to alleviate her suffering and if possible cure her condition. The postoperative care in this case became his duty even if he did not perform the operation.<sup>10</sup>

#### Abortion

There is a sharp conflict of authority on the question whether the consent of a woman to an abortion precludes a recovery. In those cases where recovery is denied, the reasoning of the courts is generally based upon the premise that the woman was either an accomplice in the crime of abortion, or a willing participant therein. Having taken part in an illegal and immoral transaction, she is barred from maintaining an action arising from such transaction.

In Nash v. Meyer, a 1934 Idaho case, a husband and wife brought an action based on the negligence of defendant physician who performed an abortion on the wife. The court held that the consent of the plaintiffs would preclude recovery from the defendant since they were participants in an illegal transaction.<sup>11</sup>

The case of Milliken v. Heddesheimer is typical of those jurisdictions which permit recovery. In that case a woman died as a result of an abortion operation. The administrator of her estate was permitted to recover damages from the physician who performed the illegal operation. The court held that the consent of the person injured by an unlawful act will not preclude recovery where such act involves a violation of the public peace or the life of the person involved.<sup>12</sup>

Other cases point out that in those jurisdictions where recovery of damages is precluded by consent, that consent must be real and valid and not induced by fraud or deceit.<sup>13</sup>

Curiously enough, it has been held that the abandonment of a woman who has undergone an illegal abortion with the knowledge that she is seriously ill as a result of such operation gives rise to a cause of action notwithstanding the consent of the woman to the operation.<sup>14</sup>

#### Rights of unborn

Until recently, the overwhelming number of states did not allow a child or his next-of-kin to sue a physician for prenatal injuries to the child. The trend has been away from that position so that today the states are about evenly divided on it.

In fact, two states, Minnesota in 1949 and Mississippi in 1954, have gone even further by allowing a suit to be maintained on behalf of child that dies before birth for prenatal injuries inflicted after it reaches the age where separation from its mother will not mean the end of its life also.<sup>15</sup>

The physician has the same duty of care toward the infant he delivers as to the mother. One of the acts of negligence most frequently alleged has been failure to avoid eye infection by treatment with silver nitrate solution, a practice required by statute in most states. There appears to be almost a presumption that eye infections following such a failure is attributable thereto.

#### Liability of hospitals

A private hospital has the duty to give a patient such reasonable care and attention as his known condition requires. The duty is measured by the degree of care, skill and diligence customarily exercised by hospitals in the community, or by its agreement with the patient. A patient enters a maternity hospital, not only to receive constant nursing care, but also the service of a doctor, when required, during the absence of her private physician.

A hospital that failed to live up to this responsibility recently had to pay an injured child \$55,000 and its father \$2,000. The child developed an intracranial hemorrhage while being born prematurely and, as a result, is an incurable spastic.

The mother, who was in her seventh month, suffered a rupture of the uterine membranes and was sent to the hospital by her private physician. In the early afternoon shortly after her admission she began having intermittent contractions, which continued with increasing frequency.

he

P.1

P.

in

th

ca

tw

he

W

B

b

statpears

that

ch a

duty

nable

own

ty is

care, arily

com-

with

rs a

v to

but

e of

live

ntly

hild

000.

tra-

sult,

her

ure

and

her

arly

nis-

nit-

tin-

ian

The resident physician gave her a rectal examination at 7:30 P.M., felt the contractions at 9:30 P.M. and then said she had nothing to worry about. Because of the patient's pain, the nurse called the resident three times between 10:15 and 11:00 P.M., but he refused to come because he was preparing to deliver triplets.

#### **Born unaided**

Shortly after 11:00 P.M. the baby's head protruded from the vagina. The nurse hurriedly brought the delivery cart, and the patient transferred herself without assistance from the bed to the

cart, and in the delivery room, from the cart to the delivery table. As soon as she settled on the table, the baby was born unaided. There was a thud as the baby's head hit the table. A private physician who was passing by was summoned by the nurse to cut the cord.

The evidence supporting the finding of negligence against the hospital was as follows: 1) the failure to call the private physician; if he or the resident were available, baby's head would have been guided out and not hit the table 2) the resident's failure to ascertain that the patient was in true labor; his failure to respond to the nurse's repeated calls 3) the failure of the nurse to call the private physician after being unable to get the resident 4) failure of the delivery room nurses to assist the patient from the delivery cart to the table and to be at her side when she delivered.16

#### Duty

It is the duty of the hospital to take reasonable precautions against a patient injuring herself while in labor. A patient, suffering from intrapartum psychosis, leaped to her death from the labor room when the nurse stepped outside to answer the

telephone. The jury was allowed to find the hospital negligent in failing to provide guard rails or locks on the windows and in failing to provide constant supervision.<sup>17</sup>

In a 1944 New York case parents were first told that they had a girl. A few days later they were told the child was a boy. The parents sued the hospital "for severe physical and mental anguish, feeling that the child given to them is not their own."

But the parents at no time claimed that the child given to them was not theirs. The court refused to allow the action since in New York there is no recovery in a negligence action for mental suffering in the absence of accompanying physical injury.

#### Within time

Plaintiff was delivered of a child on March 27, 1927. Defendant made two visits to her home, the second on April 4, 1927, in connection with complications arising after the birth. A malpractice suit was commenced April 3, 1929. The court held that the suit was brought within the two year statute of limitations.

The defendant was employed for the delivery of the child and the necessary attention following. The statute does not run while the treatment continues.<sup>18</sup>

#### **Damages**

Plaintiff complained of backaches to physician, defendant who diagnosed the cause as a tipped uterus. In fact, plaintiff was pregnant. Defendant's treatment resulted in an abortion and impairment of the nervous system. Plaintiff was awarded \$5,000 damages.<sup>19</sup>

Physician defendant failed to attend and treat pregnant patient who had a miscarriage which would have occurred in any event.

The court held the plaintiff was entitled to recover in damages for any and all pains of childbirth and following it that were not prevented or eased by physician because of his negligent failure to attend or prescribe for his patient.

The court pointed out that had the doctor attended, the child would have been born in bed; he would have prescribed narcotics to relieve the pain; the plaintiff would have had the assuring presence of a doctor; other medical care would have been taken. The court also allowed recovery for present mental suffering due to the immediate realization of what is occurring.<sup>20</sup>

while

backndant as a nintiff treatn and sysarded

ed to atient which any

olainer in ns of that ed by negliecribe

t had child d; he cotics intiff presedical . The y for ne to what

sician





## 

all things considered ...

"The catheter is probably the most common agent responsible for resistant urinary tract infections." 1

... there's a point to prophylaxis

"All instrumented patients, male or female, deserve prophylactic drugs to prevent iatrogenic urinary tract infections." 2

to meet the danger | to treat the patient

## Furadantin

brand of niggsfurantoin

"We have given FURADANTIN for as long as three months to patients with indwelling catheters without deleterious effects."

FURADANTIN Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp. REFERENCES: 1. Lich, R., Jr.: J. Arkansh M. Soc. 52:271, 1956. 2. Baker, W. J.: J. Urol., Balt. 80:85, 1958. 3. Carroll, G., et al.: J. Am. Geriat. Soc. 5:635, 1957.

EATON LABORATORIES, NORWICH, NEW YORK

#### References

- 1. Williams v. Tarter 286 Ky. 717, 151 SW2d. 783, 12 NCCA NS554 (1941).
- 2. McKinnon v. Polk 219 Ala. 167, 121 SO.539, 542.
- 3. 42 Cal. App. 2d, 761, 109 P.2d, 1027, 12 N.C.C.A. NS 578 (1941).
- 4. Hammer v. Klegger 50 S.D.453, 210 NW 467 (1926).
- 5. Warenka v. Sewall 320 Mass. 362, 69 NE 2d, 581 (1946).
- Paulson v. Stocker 4 NE 2d 629 (Ohio, 4935).
  - 7. Langford v. Jones 22 P 1064 (Or. 1890).
- 8. Pilgram v. Landham, et al. 63 Ga. App. 451, 11 SE 2d 420 (1940).
- 9. Kirchner v. Dorsey & Dorsey 226 Iowa 283, 284 NW 171 (1939).
- 10. Stejskal v. Darrow 55 N.D. 606, 215 N.W. 83, 53 A.L.R. 1096 (1927).
  - 11. 54 Idaho, 283, 31 P 2d 273.

- 12. 110 Ohio St. 38, 144 N.E. 264, 33 A.L.R. 53 (1924).
- 13. Gunder v. Tibbets 153 Ind. 591, 55 NE 762 (1899). Hancock v. Hullett 203 Ala, 272, 52 So. 522 (1922).
- 14. Andrews v. Coulter 163 Wash. 429, 1 P 2d, 320 (1931); True v. Alder 227 Minn. 154, 34 N.W. 2d 700 (1948).
- 15. Verkennes v. Cornieu 38 NW 2d 838 (Minn. 1949); Rainey v. Horn 72 So. 2d 434 (Miss. 1954).
- Garfield Memorial Hospital v. Marshall
   App. D. C. 234, 204 F 2d 721, 37 A.L.R. 2d.
   (1953).
- 17. Santos v. Unity Hospital 301 NY 153, 93 N.E. 2d, 574 (1950).
- 18. Bush v. Cress 178 Minn. 482, 227 N.W. 432 (1929).
- 19. Dennis v. McArthur 23 Wash. 2d 33, 158 P 2d 644 (1945).
- 20. Mehigan v. Skeehan 94 NH 274, 51 A 2d 632 (1947).

recorder modern crech not the wall

U



"What? You say this IS the specimen!"



A.L.R. 55 NE 1. 272,

129, 1

d 838 d 434 ershall R. 2d.

53, 93

N.W.

A 2d

#### Patients receiving

### **NILEVAR**

Eat more... Feel better... Recover faster

Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight—"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula... Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus—"Within four days appetite became excellent, took full diet... More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Dogree Burn—"...soon began eating all that was offered....Began to show signs of hope for recovery.... Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg., ampuls of 25 mg. (1 cc.) and Nilevar Drops of 0.25 mg. per drop.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

for geo (no Do

> Kii Mi

the

Th

as co rei se re

In

as

fi

# The Surgeon WHO DARED THE IMPOSSIBLE

Edward R. Bloomquist, M.D.

With his patient wide awake and reciting psalms, a Kentucky backwoods surgeon, confident of his God and his skill, began an abdominal operation that could cost him his own life if he failed.

Jane Crawford awakened early on the morning of the operation. With the help of her attendant, Mrs. Baker, she washed, dressed and was assisted to the surgery. Approaching the operating table, she sat on its edge, gingerly eased herself along its hard surface. Grasping the table edges with her hands, she reclined on her back. The patient was ready.

The surgeon, Kentuckian Ephraim McDowell, was also ready.

With this, as with all his surgery, McDowell was scrupulous in his preparation. He insisted upon studying and outlining, whenever possible, the anatomy and technical approach to the proposed surgery. His assistants were stringently rehearsed in their roles and carefully trained in anatomy, for McDowell did systematic dissections in his own laboratory.

The first part of this story appeared in RESIDENT PHYSICIAN last month.

Several people were present for the event. Assisting the surgeon were Drs. James McDowell (nephew) and Albin Smith, Mc-Dowell's associate. Charles Mc-Kinney, a medical preceptee and Mrs. Baker, attendant, completed the team.

The patient was quite awake. There was no pretense of asepsis as we know it today. Anesthesia consisted of a determined spirit reinforced by a continual flow of selected psalms which the patient recited during her ordeal.

#### Incision

ction

I.D.

ery,

his

pon

ver

ch-

sed

in-

ind

for

ec-

red

an

Stepping to the table, the surgeons removed only such clothing as was necessary to expose the field of surgery. McDowell marked the planned incision line with a pen, then, generously, gave the scalpel to his vacillating nephew.

James made a halting superficial incision, after which he returned the knife to the surgeon.

McDowell carried the incision for a length of nine inches, three inches from the lateral border from the rectus abdominus muscle. Upon opening the peritoneum, the tumor popped into view. Around it the intestines emerged; frequent moistening kept these in reasonably good condition.

Working rapidly, a ligature

was placed around the Fallopian tube and the tumor pedicle. The surgeon then incised the tumor removing some fifteen pounds of gelatinous material. With the tumor deflated, another seven and a half pounds of solid ovary was excised.

The semi-conscious patient was now rolled to her left side to empty the abdominal cavity of blood that had accumulated.

#### Completed

Surgery completed, the opening was closed with interrupted suture, the intestines having first been returned to their normal habitat. Strips of adhesive tape were placed between every two sutures to assure additional wound support. For reasons best known to him, McDowell chose to bring the ligature placed around the pedicle to the outside, through the lower end of the incision.

The operation was completed in 25 minutes, the wound dressed, and the patient carried back to her room.

#### Success

Jane Crawford proved to be a premature advocate of early postsurgical ambulation a full century before it became accepted practice. To McDowell's dismay, he



. \_\_\_



Tetracycline with Citric Acid Lederle

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



found his patient casually making her bed when he came to visit her on the morning of the fifth postoperative day, a finding that encouraged him to take precautions to prevent her being so energetic in the immediate future. He kept her at his home for another twenty days then permitted her to return home by horseback.

The "experiment" was more than successful. It gave Jane Crawford thirty-two more years of life which she lived happily until death finally claimed her at the age of seventy-nine on March 30, 1842.

McDowell was pleased but apparently not overly impressed by his pioneer effort in abdominal surgery. He credited most of his success to the will of God rather than any skill or judgment on his part.

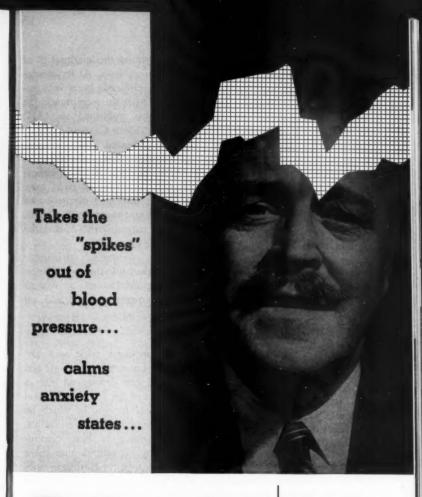
Because of the favorable outcome of his first case, he soon attempted two additional cases, both successful. But it was seven years before he got around to reporting his epochal work. Disinterested in writing and not particularly convinced he had done anything spectacular, he would not comply with the urgings of his nephew James and cousin William, also a physician, who saw the importance of making the work known.

**Apprentice Doctor** 

Ephriam McDowell wanted to be a country physician. Apparently, his parents concurred with his desire for they permitted him, at the age of nineteen, to become an apprentice to Dr. Alexander Humphreys of Staunton, Virginia.

Humphreys, a graduate of the University of Edinburgh, was an aggressive, up-to-date physician. He was a careful anatomist and taught his apprentices anatomy by dissection. This, unfortunately, created a personal problem which became so great he was forced to leave the state.

In 1788, an Englishman William Richardson Watson disappeared. Shortly thereafter a bag of human remains was found in a cave: the remains bore the undeniable stamp of recent anatomical dissection. Humphreys was slandered by local gossip linking him with the dissection and possible murder of the missing man. Law suits followed, and although testimony was introduced clearing Humphreys of this crime, additional facts were presented which showed he had been guilty of disinterring at least one body and using it for teaching purposes. Town sentiment and the resulting ugly attitude caused Humphreys to leave for Kentucky.



## **Butiserpine**°

The Butisol component acts at once to produce its well-known quieting "daytime sedation." And the small dosage of reserpine gradually builds up its tension-suppressing effect, without the disturbing side reactions of larger dosage.

parwith nim, ome oder nia. the an

and by

cre-

to

an lis-

ag n a

nias

ng osm.

gh ng lich sid

5.

E

0

an

Quiescence is prescribed when you use Butiserpine.

Each tablet or teaspoonful of elixir contains: BUTISOL SODIUM® 15 mg. (1/4 gr.) Butabarbital Sodium

Reserpine 0.1 mg.
Prestabs® Butiserpine R-A (Repeat Action Tablets)



McNEIL LABORATORIES, INC. Philadelphia 32, Pa.

#### Report

When McDowell at last got around to writing a not too literate story of the surgery, it was apparently due to the argument on the part of supporters that it would please his teacher John Bell. He made two copies of his manuscript. The first he sent to Dr. Bell, the other to Dr. Phillip Syng Physick of Philadelphia with the request it be published if found worthy. Physick, an important surgeon of a prominent family and with a more than adequate educational background, sensed a controversy, deposited the manuscript in "file thirteen."

The manuscript intended for Bell fell into the hands of John Lizars, a competent physician who had taken over Bell's practice after the latter became ill and left for Italy to rest. Lizars for the moment was not too impressed. Thus, the paper that had taken seven years to come into being was laid on the shelf.

#### Published

William McDowell was not willing to let the matter drop, however. He obtained a copy of the article and personally took it to Dr. Thomas C. James, Professor of Midwifery at the University of Pennsylvania and an editor of Eclectic Repertoire. The profes-

sor presented the manuscript at one of his classes. At its conclusion the audience burst into applause. After this acceptance, the paper was published in 1817. Entitled "Three Cases of Extirpation of Diseased Ovaria," it appeared in volume 7, page 242 of Dr. James's journal. Its publication created a world wide reaction that displaced discussion of other current events to that of the frontier surgeon who had dared to do the impossible.

de

to

ta

CC

lia

in

ai

C

th

to

iı

1

Many, however, stringently disapproved of the occurrence, branding McDowell a woman butcher, quack and out and out liar.

#### Critics

His principal critic was Dr. James Johnson whose caustic and unethical pen denounced him in the pages of the London Medical Chirurgical Review in which he was permitted to write editorials. His prejudice is best demonstrated by his remark that there was little hope for European doctors to compete with McDowell even if he had accomplished an oophorectomy, which Johnson completely doubted, because all patients "of this backwoods doctor," with one exception "were slaves who bore cutting with the impunity of a dog."

In October, 1824, John Lizars decided to attempt an oophorectomy. Although it must have taken a great deal of personal courage and integrity, he reported his results. His long brilliant dissertation was one reporting failure, inadequate diagnosis and a superabundance of faulty consultation occurring beneath the protective shadow of an ivory tower of medical training. In this report of his own failure he included McDowell's complete manuscript as a quotation, giving McDowell credit for his original work.

pt at

nclu-

o ap-

e, the

1817.

tirpa-

t ap-

42 of

blica-

reac-

on of

of the

lared

ently

ence,

man

out

Dr.

and

n in

dical

n he

rials.

non-

here

doc-

well

an

ison

all

loc-

vere

the

cian

Much can be said about John Lizars. He was extremely honest. His contemporaries considered him an excellent surgeon. Despite this, this is the record of his attempt at abdominal surgery:

On Wednesday, October 24, 1823, surrounded by a retinue of prominent surgeons, he made an incision that reached from the ensiform cartilage to the pubis. Having given himself this liberal exposure to the abdominal cavity, he became extremely anxious, with good reason, that his patient might die from "peritoneal inflammation" as was currently taught in better medical circles. Attempting to prevent this, he wrapped the well visualized intestines in towels moistened with

Presidents' Precedents

McDowell's record of successful lithotomies should also be mentioned. According to Gross he did thirty-two of these without loss of a life. One of his most spectacular lithotomies was performed upon a seventeen-year-old boy who came to him for surgery in 1812 for removal of a bladder stone. Some days later the boy walked home with the stone in his pocket, a mute reminder of his previous problem. Understandably, he always retained admiration for his benefactor, and later, when James K. Polk became president of the United States, he remained in contact with the doctor who made his later political success possible by restoring his health.

In the summer of 1822, Mc-Dowell was called to go several hundred miles by horseback into the interior of Tennessee, to perform an oophorectomy on Mrs. Overton. The case presented a particular problem because the patient was extremely obese and the surgeon needed help traversing the four inches of fat that overlaid her abdominal muscles. Fortunately, he was able to obtain assistance of two neighbors. One was a lady, Mrs. Priestly. The other a wellknown general, Andrew Jackson. Mr. Jackson is the only U.S. president who ever served as first assistant at a major surgery.

water heated to body temperature. Then, he looked for his tumor.

Regrettably it turned out to be an accumulation of fat.

In 1825, on three separate dates, February 27, March 22, and April 24, Lizars made three more attempts. One patient died, one recovered. The third never received complete surgery inasmuch as technical problems arose and the surgeon rapidly discontinued the operation.

Noting this remarkable series of performances, the surgeons of Scotland discontinued attempts at abdominal surgery until 1845 when Edinburgh's Dr. Handyside revived the procedure.

#### Criticism and apology

Irritated and appalled by the storm of contempt and disbelief which his manuscript had stimulated, McDowell published two additional articles. One of these was a short card directed to the students and faculty at Transylvania University in 1826 in which he defended his actions. The other entitled, "Observations On Diseased Ovaria" was published in September, 1819, in the Eclectic Repertoire. In this he reiterated the principles set forth in his first paper and added two more successful cases. He took occasion at this time to tee off on inadequately trained surgeons who attempt to do procedures for which they were not qualified.

In London, Dr. Johnson was still ranting away. In January, 1825, he reaffirmed his stand against McDowell with the statement:

In spite of all that has been written respecting this cruel operation we entirely disbelieve that it has ever been performed with success nor do we think it ever will.

But in October, 1826, the garrulous editor was forced to eat humble pie.

With reluctance, he wrote the following editorial:

A back settlement of America—Kentucky—has beaten the mother country, nay, Europe itself, with all the boasted surgeons thereof, in the fearful and formidable operation of gastrotomy, with extraction of diseased ovaria . . There were circumstances in the narrative of some of the first three cases that raised misgivings in our minds, for which uncharitableness we ask pardon of God and of Doctor McDowell of Danville. . . .

In time other British authors followed suit in admitting oopho-

n inwho for d. was vary, tand tate-

een wel ve ed it

the eat

the

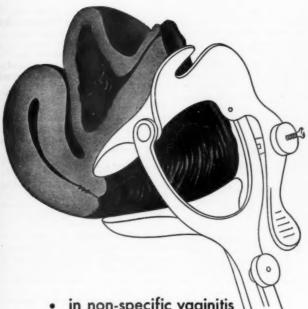
ca ie ie ie rid iid

e d r k

ors o-

an





- in non-specific vaginitis
- in postpartum care
- after vaginal surgery

## **Triple Sulfa Cream**



#### Physicans turn to Tessalon<sup>®</sup> to control cough Single agent with multiple actions broadens cough therapy

A single therapeutic agent developed by CIBA research now does all that has been attempted with combination cough remedies. Extensive clinical trials, involving more than 3,000 patients with acute or chronic cough, have shown that TESSALON has at least six advantages that result in better total management of the patient with cough:

- 1. TESSALON acts peripherally, to control cough in the chest.
- 2. TESSALON acts centrally, to control cough at the level of the "cough center" in the medulla.
- 3. TESSALON is reported to thin sputum.1
- TESSALON increases vital capacity and ventilation.
- 5. TESSALON improves exercise tolerance.
- 6. TESSALON relieves dyspnea.

#### Fewer coughs per minute

Shane and co-workers, 2 using the method of Bickerman and Barach, 3 induced measurable cough in 20 volunteers, using a 15 per cent citric acid aerosol as the cough-producing agent. The antitussive efficacy of TESSALON (100 mg.) was estimated to be 2½ times that of codeine (½ grain) in this test.

Cough suppressing activity of TESSALON <sup>2</sup>		
	Average Number of Coughs	
No therapy	8.3	
Codeine	4.4	
TERRAL ON	17	

\*Based on 5-minute interval immediately following inhalation of citric acid to induce cough. Each patient was tested on three separate occasions.

#### Controls cough in the chest

It has been shown that the increased sensitivity of the sensory receptors in the lung during inspiration is an important part of the cough mechanism. TESSALON has a selective inhibiting effect on these dilation or "stretch" receptors that helps to control cough where cough begins—at points of irritation in the chest.

#### Controls cough at the cough center in the medulla

Spinal reflex arcs were studied for the inhibstory effect of TESSALON on the transfer of afferent cough impulses to the efferent branch of the cough reflex. The administration of TESSALON inhibited reflex transmission, when the afferent nerve was stimulated electrically. With this "damping" effect on the cough center in the medulla, TESSALON controls cough centrally, as well as peripherally.

#### Thins sputum

TESSALON controls cough frequency without interfering with productivity or expectoration. In fact, sputum is usually thinner, easier to raise.<sup>1</sup>

Amount		Consistency	
Less	32 patients	Heavier	3 patients
More	2* patients	Lighter	27 patients
Same	16 patients	Same	20 patients

#### Increases vital capacity

Respiration usually increases both in depth and volume during TESSALON treatment. In one study, patients with chronic respiratory disease, with and without bronchospasm, showed a mean increase of 19.7 per cent in vital capacity after a 2-week course of TESSALON.

#### Improves exercise tolerance

By inhibiting stretch receptor activity, and by increasing air intake, TESSALON enables patients to tolerate exercise or work better, eliminates many paroxysms of coughing.

#### Relieves dyspnea

Farber and Wilson note that one of the important contributions of TESSALON to cough therapy is "...its action as a reliever of dyspnea in some patients." Shortness of breath, wheezing, weakness, "blackouts" are not likely to trouble the patient treated with TESSALON.

#### Fast, prolonged action

The cough suppressant effect of TESSALON starts rapidly—usually within 15 to 20 minutes. The duration of effect is prolonged—usually from 3 to 8 hours.

ications
SALON i
gh.
TE: Co

nia, Up

, Spont

tation jies. CH mehitis onchita onic pudiastina ocedura hy, Th

sage uLTS: z.) t.i.o fractor by be a uLDRE 0 mg. he Per ewing,

elease

outh p
a of the
de Eff
ESSALO
have:
asal co
on hav
astroir
on hav

lood of upplication of the providence of the pro

Refer . Simo . Shar i.A.J. barach i.J. is:55 ( onal onal o be

TESSA

ugh y

fferent nistransmisulated ect on SALON eriph-

ithout ctorainner.

tients tients tients

lepth tory asm, nt in e of

and bles ter. g.

imugh spth. not ith

ON in-

n

ications

SALON is indicated in acute and chronic

TE: Common cold, Bronchitis, Pneunia, Upper respiratory infection, Pleu-, Spontaneous pneumothorax, Bronchial tation provoked by gases and foreign ies. CHRONIC: Pulmonary emphysema, nchitis (emphysematous, asthmatic), onchial asthma, Tuberculosis, other onic pulmonary diseases, Pulmonary or diastinal tumors

ocedures: Bronchoscopy and bronchogby, Thoracentesis, Thoracic surgery

ULTS: Average dosage is one Perle (100 .) t.i.d. If necessary, or where cough is fractory, up to 6 Perles (600 mg.) daily y be given.

ILDREN UNDER 10: One Pediatric Perle 0 mg.) t.i.d. is the usual dosage.

e Perles should be swallowed without wing, and, if necessary, with a liquid. elease of TESSALON from the Perle in the outh produces a temporary local anesthea of the oral mucosa.

de Effects

ESSALON is well tolerated. Only occasionalhave side effects been reported. Skin rash, isal congestion and a vague "chilly" sensaon have been mentioned. In rare instances, astrointestinal upset, constipation or sedaon have been observed. No adverse effects n respiration, kidney or liver function tests, lood count or urinalysis were reported.

upplied erle form (liquid-filled gelatin spheres) rovides speed of liquid medication-conenience and dosage accuracy of capsule nedication. In two strengths: 100-mg. erles (yellow), for adult use; 50-mg. erles (red), for children under 10.

Samples available on request.

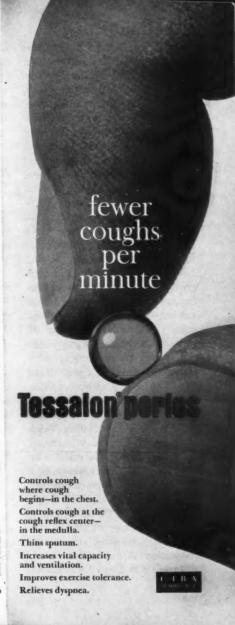
References

N. J. CHROES

Simon, S. W.: Ann. Allergy 15:521 (Sept.Oct.) 1957.
Shane, S. J., Krzyski, T. K., and Copp, S. E.: Canad.
A.J., 77:560 (Sept. 15) 1957. 3. Bickerman, H. A., and
brach, A. L.: Ann. J. M. Sc. 228:156 (Aug.) 1954. 4. Belot.
555 (March) 1957. 5. Meley, R. and Bein, H. J.; Peronal
communication. 6. Michelson, A. L., and Schiller,
W.: J. Allergy 28:514 (Nov.) 1957. 7. Bickerman, H.
c) be published. 6. Farber, S. M., and Wilson, R. H. L.:
(0 be published. 6. Farber, S. M., and Wilson, R. H. L.:

ESSALON® (benzonatate CIRA)

s/imim



rectomy was, indeed, a possible procedure. Some, however, like Spencer Wells, did more than jump on the bandwagon-they loaded it with mildewed hay. Trying to prove the procedure had really originated in Great Britain. they credited English surgeons, such as Dr. Robert Houstoun of Glasgow who punctured an ovarian cyst in 1701, draining it of its fluid then closing the small puncture wound, as being an example of several British surgeons who had preceded McDowell in performing the operation. Right, however, prevailed and in its own good time permitted McDowell to become generally recognized as not only the "father of oophorectomy" but, quite probably, of modern abdominal surgery itself.

Capable of performing with distinction all surgical procedures known to his day, as well as those which were his own innovations, McDowell is credited with having crossed the Atlantic three times to perform Caesarean sections, two of which were successful. The only proof of this, however, is a testament of his granddaughter who frankly states that only members of his immediate family knew of his trips. There is, unfortunately, no other known corroboration of this statement.

In 1830 McDowell was reach-

#### Source of Strength

During surgery, McDowell was known to be deliberate and accurate. He had to be! He had no relaxation, no anesthesia, no modern instruments as we know them today. He operated with intense concentration, sweating liberally, regardless of season or temperature.

ing th

noon

as the

sided

of his

berry

ered

patch

In a

ill. I

cons

dom

vom

sym

tres

an

ston

felt

bug

bec

doo

ord

sug

las

tal

M

ab

an

flu

ga

he

n

p

He liked to operate on Sunday. First, it was quiet—little other activity was planned for that day. Secondly, he felt support in the idea that the congregations were praying for him as he worked.

Much of his surgery was performed in the patient's home. The rest he did in his own home, for Danville did not have the luxury of a hospital. His intense religious spirit was apparently a source of strength to both him and his patients. He was never known to operate without a session of prayer. Frequently, he would write his prayers on a slip of paper, carrying them in his vest as he operated.

He was known as an excellent surgeon, but a "poor fever doctor." This is not surprising considering his contempt for internal medicine, a contempt which prompted him, whenever possible, to turn all such cases over to his associates. He kept few records, disdaining to write much of anything except his pre-surgical prayers. ing the peak of success. One afternoon on the twentieth of June as the press of duties briefly subsided, he permitted himself one of his few overindulgences. It was berry time, and McDowell wandered through his burgeoning berry patch, sampling the fresh fruit. In a few hours he became acutely ill. Fellow physicians, called in consultation for the severe abdominal cramps, nausea vomiting that were the uneasy symptoms of his underlying distress, diagnosed the problem as an acute inflammation of the stomach. McDowell disagreed. He felt he had swallowed a poison bug.

was

ac-

d no

nod-

hem

ense

ally,

per-

day.

ac-

lay.

ere

er-

The

for

iry

SUC

of

98-

to

iyhis

y-

er-

nf

g

e,

n,

h

e

o

an

Within a short time the pain became worse and the attending doctors, sensing this was no ordinary problem felt advised to suggest that if McDowell had any last business he might be wise to take care of it now. For Ephriam McDowell, who as far as he was able had made his peace with God and man, this advice was superfluous. With family and friends gathered around him he stated he had made all the arrangements necessary. He acknowledged the possibility of imminent death, but denied any fear of the unknown.

"I close my eyes in death," he

said, "forgiving those who have done me any injustice. And with a happy and peaceful assurance of soon being with Him Who has ever guided my earthly pilgrimage, Who forgiveth . . ."

He paused in the middle of his sentence, possibly to enjoy for the last time the warm Kentucky evening breeze as it moved gently over his stolid face.

It is ironic that he should die as he did. Had fate decreed otherwise, and he had been doctor rather than patient, it is possible he might have been able to save a life by performing another notable first. For Ephriam McDowell had an acute appendix which, upon rupturing, caused his death.

The death was premature. But though limited in years, Mc-Dowell's life was crammed with unprecedented efforts to help humanity. A man of action, he lived by faith. With the self assurance and trust in his God which served him in life, so too, he entered the valley of death.

June 20, 1830. The sun faded and the country home of Ephriam McDowell became quiet. It was evening. And for Dr. Ephriam McDowell, pioneer surgeon, the time for action has passed.

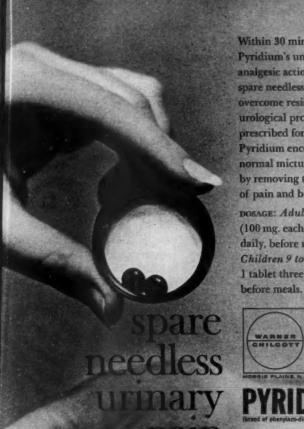
# How to Equip the Ophthalmology Office

Space arrangement is particularly important to the ophthalmologist. Here's what a survey of practitioners in the field reveals about office equipment needs in their specialty.



In setting up an eye office, the first thing the prospective ophthalmologist should do is to decide on the number of rooms and their layout," reports one respondent.

First consideration, say the eye specialists, should be in establishing a 20-foot examining distance for testing visual acuity. This actually means a floor dimension something in excess of 20 feet. And locating such a room is in itself no small problem. (Some respondents mentioned modifications which permit the use of a less than 20-foot examining distance. "But these," according to one, "usually lend confusion to an examination where relaxation



Within 30 minutes. Pyridium's unusually prompt analgesic action will spare needless pain and help overcome resistance to urological procedures. When prescribed for home use, Pyridium encourages more normal micturition by removing the penalties of pain and burning. DOSAGE: Adults: 2 tablets. (100 mg. each), three times daily, before meals. Children 9 to 12 years: I tablet three times daily



of the patient is important.")

Other space will include a waiting room, reception room, examining room and perhaps a dark room where many of your basic examinations can be made. However, some ophthalmologists note that if a large amount of space is not available, the latter three rooms can be combined into a single room.

If a separate dark room is decided upon, it should be painted in dark gray or black.

"Only a few simple wall lights or a dim ceiling light should be installed; many eye examinations are purposely accomplished without external illumination, using only the illumination with which the various instruments themselves are equipped," reports one ophthalmologist. The majority mentioned this point. One said he had installed a variable lighting switch-rheostat control by which "any degree of light can be obtained."

#### **Furniture**

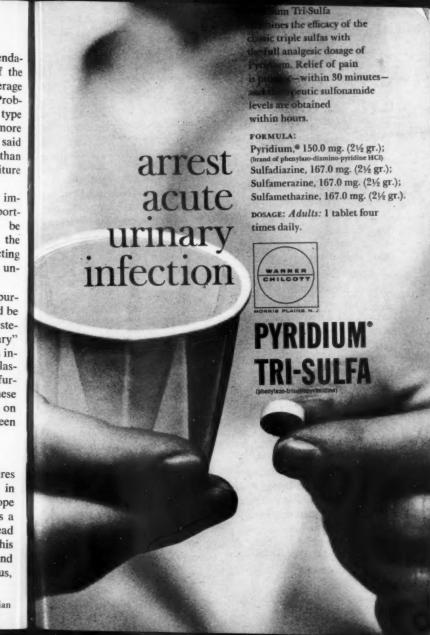
Eye specialists agreed the reception room should be simply furnished, "without too many embellishments"; and it should be free of shiny, light-reflecting surfaces, "discomforting to a patient coming in for an eye examination." Office furniture recommendations touched upon most of the usual types seen in the average medical or surgical office. "Probably, conservative wooden type furniture is best because it is more dignified in appearance," said one. "Less brassy looking than the average metallic furniture and also not so glary."

This "glare" business is important. One respondent reported: "Glare is strictly to be avoided. It interferes with the examination and is distracting and annoying to the patient undergoing the examination."

However, even though the purchase of office furniture should be directed towards "simple, tasteful, subdued and non-glary" pieces, many ophthalmologists indicated that coarse-textured plastic, leather, and upholstered furniture would fill the bill. These pieces of furniture, depending on the materials used, range between \$50 and \$70 each.

#### First consideration

The ophthalmologist acquires an ophthalmoscope (\$50) in medical school, and a retinascope (\$40) later on. Usually, he has a binocular eyeloop (either a head type or one that fastens on his glasses or behind his ears) and one or more pocket lights. Thus,



ndathe rage robtype

nore said than

imortbe the

ting unour-

l be stery" inlas-

furese on een

res in pe s a ad his nd

an

us.



first consideration will be directed towards the purchase of the bulkier items of specialized office equipment.

#### **New equipment**

Should the prospective ophthalmic surgeon purchase new or used equipment. "Eye equipment," one doctor stated, "if handled with care, can be made to last a lifetime." Said another: "You never can be certain that used equipment will be serviceable. And since all eye examinations must be carried out with meticulous care, only that equipment which lends itself to producing perfection should be purchased."

Of the minority, most agreed new equipment was better; "... but sometimes you just don't have an alternative because of cost."

#### Basic

The first pieces of equipment to consider are the specialized eye chair, the trial lens set, lens cabinet, testing charts, and the trial-frame for mounting testing lenses on the patient.

In addition to these, a number of items of equipment are essential to the refraction examination.

#### Refractometers

Most specialists use the lens set with a multitude of individual, vari-sized lenses, prisms, and special lenses. However, refractometers are available with lenses which can be swung into place before the patient's eyes. While these are "compact and very convenient," according to some eye specialists, others hold them to be "expensive and bulky."

Before purchasing, the prospective surgeon should be certain, say many respondents, that sufficient office space is available for a refractometer. Careful measurement of space and equipment is necessary. Refractometers with mounted lenses can be bought from \$800 to \$1000.

#### Charts

Eye testing charts are available in the form of cards, illuminated boxes, and as slides projected on a screen. The latter are "excellent" according to the majority of ophthalmologists responding, "from the point of view of conlens the esting

mber ssention.

lens dual, spetomnses blace /hile very

ome hem

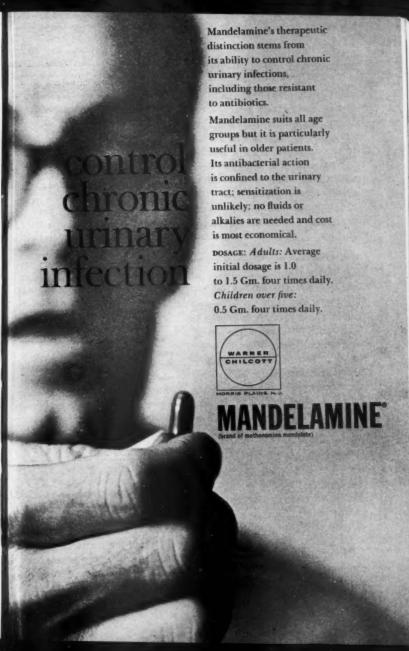
that able eful aip-

omcan 00.

ble ted on exity



n-



venience and maneuverability."

The reading test charts, especially calibrated for the near distances, can be purchased or can usually be obtained gratis from the optical equipment manufacturer or retailer.

Trial frames (around \$75) come in a variety of forms (and prices). During his residency the eye man has a chance to use many types and can usually get an idea of which suits him best.

#### Lens racks

Lens racks are convenient accessories for determining quickly a rough estimate of the refractive error. These racks hold a graduated series of lenses in the minus and plus strengths with which the basic refraction can be quickly assessed before going on to further refinement. These can be purchased for about \$25. In addition a set of cross cylinders will speed and abet the accuracy of the examination.

Testing color vision, although done by many methods, can be accomplished by the pseudo-isochromatic charts. These charts can be purchased from a number of sources. Prices vary from \$15 to \$25.

Three other pieces of office equipment are considered basically essential to the eye practi-

132

What equipment is needed by the ophthalmologist who is completing his residency and preparing to open an office?

RESIDENT PHYSICIAN recently put this question before a number of practicing eye men. Cautioned to keep in mind that cost was an important factor for the new man starting out, many responding ophthalmologists described some of the costly mistakes they had made when equipping their own offices.

Based on their experiences, this article is presented as a general guide for those residents who will soon be equipping their own offices for the practice of ophthalmology.

Though such things as decor, style and layout of an office are best decided by each physician (or his wife), the resident would be wise to visit an office equipment firm since many offer a free consulting and advisory service. Some will even furnish your entire office on the cuff — and at reasonable bank rates,

tioner. These are the slit lamp (cost from \$450 to more than \$1000), the lensometer (\$350-\$500), and the perimeter (\$250-\$300). Incidentally, these and other optical pieces are available in both U.S. and foreign manu-

facture made manu service impo the p

Orth

the ployer come thop study tions or o

quir orth

> a la for ever chie add acc cha

> > agr

ear

fo

F

facture. When dealing in foreign made equipment, reliability of the manufacturer and availability of service and parts are especially important factors, according to the panel.

#### Orthoptic

v the

leting

g to

re-

ore a

men.

that

r for

many

pping

this

neral

will

ffices

logy.

ecor,

are

(or

be

nent

con-

ome

ffice

able

amp

than

350-

250-

and

able

ınu-

ician

detakes Other instruments available to the ophthalmologist, and employed by many in their practices, come under the heading of orthoptic instruments; used in the study and training of eye deviations due to defects, weaknesses, or other involvements of the extra-ocular muscles.

This equipment usually requires a full-time assistant, an orthoptic technician.

Or the doctor must set aside a large portion of his own time for using these instruments. However, in the beginning practice, chiefly because of "time plus the added cost of trained assistants," according to respondents, the purchase of orthoptic instruments seldom proves to be "a good early investment."

Yet, most ophthalmologists agree that some simple orthoptic instruments, such as a stereoscope (\$10) and a set of cards, do have ready use.

"The doctor can use these for quick evaluation of muscle deviation and as an instrument of THERE ARE two ways in which a resident can help himself avoid mistakes:

- Consult an office equipment company which maintains an advisory staff having experience in equipping doctors' offices.
- Make a tentative list of equipment items you think you'll need together with cost estimates.

instruction to the parent whose child has a low grade muscle error." Incidentally, the specialist should have a separate box of prisms with which to measure muscle deviation. In this examination he will be aided by the special lenses found in every lense testing set.

#### Other equipment

Another instrument which members of the panel termed necessary is the ophthalmometer (\$425), valuable in measuring the corneal surface and of some use in measuring the astigmatic area in difficult cases of refraction. However, some ophthalmologists indicated that other measuring methods were adequate for the needs of the beginning specialist.

An essential piece of equip-

ment is the perimeter for testing central visual defects. Certain perimeters are equipped with a slate which takes the place of the tangent screen. However, eye men, who like to do refined perimetric measurements, indicated that the older type tangent screen, the large screen, is often better for their purposes. This type can either be purchased or made in accordance with measurements found in texts on perimetry.

A specialized instrument for measuring central fields is the campimeter (\$300).

The gonioprism (\$60) was considered optional by the majority of respondents. While many eye men did not find this "practical for office use," others indicated it is "essential for a detailed and more refined examination" in certain types of cases and in studying the anterior chamber angle of the eye.

#### Illumination

Some form of movable, condensed illumination is needed in the office; one which allows the doctor to have the availability of both hands, instead of tying one up with a pocket light or some other light, is preferable.

Another essential piece of illumination is called the transilluminator. This comes in many forms and from many different manufacturers. The physician will select one most suitable and convenient for his purposes.

The tonometer for measuring intra-ocular pressure is essential and indispensable. Average price runs from \$25 to \$55.

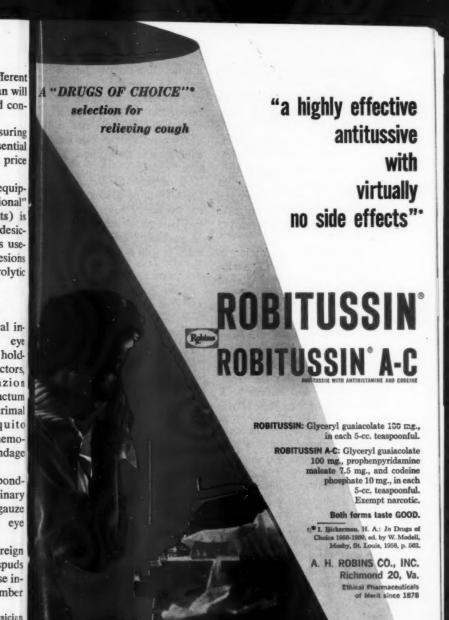
A good, useful piece of equipment (though listed as "optional" by a number of respondents) is an electrical coagulator or desiccator. Such an instrument is useful in removing small lesions about the lids and in electrolytic epilation. Price about \$75.

#### Surgical instruments

A suggested list of surgical instruments would include: eye scissors, eye forceps, needle holder, eye speculum, lid retractors, chalazion forceps, chalazion curettes, surgical knives, punctum dilators, lacrimal probes, lacrimal irrigating cannulae, mosquito clamps or other type of hemostatic forceps, and bandage scissors.

Other items listed by respondents include eye sutures, ordinary surgical dressings such as gauze and cotton, antiseptics, eye patches and adhesive.

For the removal of foreign bodies a variety of eye spuds should be purchased. All these instruments are made by a number



of manufacturers, American and foreign.

Ophthalmologists reported that stainless steel instruments found their favor more often than the chrome plated. Though more expensive than chrome, stainless steel "proved more economical" due to durability over a longer period. The cost for these surgical instruments, depending on make and finish, may vary between \$75 and \$150.

"Indispensable," according to most ophthalmologists is "a wide variety of medications." A broad group of drops and salves are essential to the care of the various eye conditions met with in the usual office practice. Among these are the miotics and mydriatics, the antiseptics and the anesthetics; and also the emollient drops and salves." A "medium sized" sterilizer is also

a must, "It would be false economy to purchase the smaller types of sterilizers," according to one respondent. "Though useful for small items, they are not of any use where a large amount of equipment is to be boiled at one time."

needles will be needed. The doctor frequently has to administer various type of medications such as antibiotics and tetanus antitoxin as well as the steroid prep-

DR BROWN

A variety of syringes and

quat ator \$12 Prin

aratio

jectab

by the

his p

day,

vacci

antib

refrig

ophtl

pract

one o

most

roon

store

A

A

cide clud bud por loo 'pr you oth kno son

> etc ex ne wi

> > Fe

cas

E

MTU

.... 1111

111 111 arations, to mention a few injectables.

A small refrigerator is needed by the eye man for the storage of his perishable medications. Today, the eye specialist uses many vaccines, biologicals, steroids and antibiotics. Thus, a satisfactory refrigerator is "as essential to the ophthalmologist as to any other practitioner in medicine," said one eye specialist.

According to another: "While most of these things are stable at room temperature, it is better to store such medications under adequate refrigeration." A refrigerator can be purchased for about \$125 to \$150.

#### Printing

econ-

types

o one

ul for

of any

int of

at one

and

e doc-

inister

such

anti-

prep-

sician

There are a number of incidental items which must be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community know you're in business) personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about \$60 to \$70. In-

cidentally, there are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms, stationery, and a bookkeeping system from these specialists. In most cases, you can make all such arrangements by mail.

The foregoing represents the basic needs of the beginning ophthalmologist, according RESIDENT PHYSICIAN poll. While there are a multitude of other things "which can be poured into the average ophthalmologist's office," reports one man, the selection made in this discussion of essential and borderline equipment comprises an average estimation of that equipment which will be basically useful to the carrying out of a proper eye examination and treatment. Prices in all cases are for new equipment and give only the approximate range for each category.

The editors have attempted to give our resident ophthalmologist readers an overall view of the cost of outfitting the beginning office in ophthalmology. Many items are omitted. Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price. In modern day merchandising, credit terms can be made

so attractive to the beginning practitioner than in many cases it may be wiser to purchase an income-producing item on credit, rather than to defer it.

#### Cost

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, including any items such as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you

may be able to do without.

Most (65%) ophthalmologists reported they had spent under \$4000 for equipment. A second group comprising 30%, expended between \$4000 and \$5000, while the remaining 5% ranged from \$5000 up to \$7350.

A WC

prot

bloc

con reli rep blo

res

It is well to keep in mind that many forms of financing are available to the beginning specialist. As a general rule, however, your bank and the manufacturer of your equipment offer the most attractive plans.

#### DELIVERY UNIT



". . . no Cedric, I think fundic pressure will suffice in this case. But thank you anyway for your inspirational innovation".

A workhorse "mycin" for common infections

gists

ınder cond

nded

while

from

that are

spehowanu-

offer



### respiratory infections

prompt, high blood levels

With well-tolerated Cyclamycin, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

consistently reliable and reproducible blood levels

minimat adverse reactions



### CYCLAMYCIN

Triocetylaleandomycin, Wyeth



Conforms to Code for Advertisi



Philadelphia 1, Pa.

ician



Sir Henry Wellcome aboard the floating laboratory.

140

Resident Physician

F.

In ceiv kni wa the dis oth

ph are

ha en m ar

F

# RGHS and WELLCOME Adventure in Drugmaking

In 1880 two young Americans teamed up in a pharmaceutical enterprise in London. Their products won quick acceptance and their small business grew into a vast organization with outlets all over the world.

In 1932 Henry S. Wellcome received two high honors. He was knighted by King George V and was named an honorary fellow of the Royal College of Surgeons, a distinction shared by only a few other non-medical men.

Without doubt, Wellcome—pharmaceutical manufacturer, archaeologist and philanthropist—was at this time one of England's leading citizens. And he had gained this place of eminence entirely through his accomplishments. He was not a member of an old English family, but was in

fact a product of the American frontier.

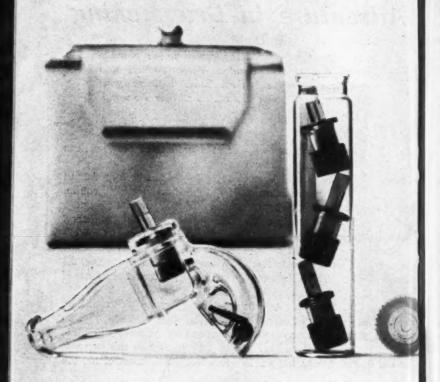
Wellcome was born on August 21, 1853, in Almond, Wisconsin, when this was still Sioux country. He was the son of a missionary, the Reverend Solomon C. Wellcome and Mary Curtis Wellcome. When the boy was about five, the family migrated west in a covered wagon.

When Solomon Wellcome took over his brother's drugstore in Garden City, Minnesota in 1866, he little knew how this step was to affect the fortunes of his son

tory.

cian

A simple way to relieve the bronchospasm of asthmatic patients



How much is a breath of air worth? To a patient in the grip of bronchospasm, it is beyond price. Yet it is easily attained, by means of the simple kit pictured at left.

The active agent is Norisodrine Sulfate Powder. You may use it for quick symptomatic relief in all grades of bronchial asthma.

Your patient takes the Norisodrine powder by oral inhalation when needed. The particles are tiny enough (90% of them are less than 10 microns in diameter) to penetrate deep into the tracheobronchial tree. There they promptly dissolve on the mucous membrane, and enter the bloodstream. Within but few seconds after the patient inhales, the smooth muscles of his bronchial tubes begin to relax. Two or three inhalations are usually enough to abort a bronchospasm.

Administration is by the Aerohalor (J-shaped device in the photo). Your patient simply breathes in lightly through the mouthpiece. Air pressure draws a metal ball against the Norisodrine cartridge, shaking down particles into the airstream.

Pharmacologically, the action of Norisodrine is almost as rapid as injected agents. Moreover, the patient can use the Aerohalor upon an instant—far faster than he can perform a self-injection. Since prompt administration is invaluable in a bronchodilator, the advantage is clear.

The Aerohalor has no liquids to spill, and can be carried in pocket or purse. It is, in fact, small enough for your patient to conceal in the palm, and use without attracting attention.

Side effects have generally been easy to avoid, because dosage can accurately be adjusted to each individual's needs. There is no systemic pressor action of any significance. Neither is there any local vasoconstrictor effect. Bronchial secretions are not diminished. Indeed, Norisodrine often brings on a more abundant flow, making mucus easier to cough up.

Norisodrine Sulfate Powder is supplied in 10% and 25%, and is available with Aerohalor and dust-tight carrier. Would you like detailed literature? Ask your Abbott man. Or write

Abbott at North Chicago, Illinois.

#### NORISODRINE

(Isoproterenol Sulfate, Abbott) Sulfate Powder

abbott

in the AEROHALOR®

Henry, who then aged 13, assisted him in supplying the frontier community with medicines.

At an early age Henry Well-come moved to Rochester, Minnesota, where he worked with a firm of pharmaceutical chemists from 1868 to 1871. It was there that he came under the notice of Dr. William Worrall Mayo, father of the late Drs. William J. and Charles H. Mayo, founders of the internationally famous Mayo Clinic. Wellcome was a boyhood friend of the Mayo brothers, and this friendship was continued during his life.

The senior Dr. Mayo encouraged the young man to study pharmacy in his dispensary and arranged for his matriculation at the Chicago College of Pharmacy. During his attendance, the Chicago fire destroyed the college. He then enrolled at the Philadelphia College of Pharmacy, and at the age of 21 was graduated as a member of the class of 1874. It was in Philadelphia that Henry Wellcome first became friendly with Silas M. Burroughs, who was to become his business partner several years later.

Following graduation, young Wellcome went to New York and joined the firm of Caswell, Hazard & Co., a pharmaceutical house of high standing and repu-

tation. During this association Wellcome continued in spare time to attend scientific lectures and to study under private tutorship. He began to contribute articles to the American Journal of Pharmacy and The Pharmacist. These articles aroused considerable interest among the pharmaceutical profession and brought him into communication with many of the leading pharmacists of America. He cemented friendships with such prominent men of the day as Professor John Maisch of Philadelphia and Professor Albert E. Ebert of Chicago.

dina

was

busi

He

adel

187

pres

It v

SOO

mee

pan

Fot

rou

con

the

bee

tag

on

dis

bu

sei

tic

ap

SC

la

in

es

m

F

#### Change

After two years with Caswell, Hazard, he resigned and accepted a position with McKesson & Robbins. Here his work in the manufacturing department required him to travel to various parts of the United States and Canada, and into Mexico, Central and South America.

In South America he had the opportunity to study the native cinchona forests. His findings were read before the American Pharmaceutical Association and published in its *Proceedings*.

At the same time, Silas Burroughs was also getting on in the pharmaceutical field. He was born on December 24, 1846 in Me-

dina, New York, and in his youth was associated with a retail drug business in Lockport, New York. He was graduated from the Philadelphia College of Pharmacy in 1877, his thesis being "The Compression of Medicinal Products." It was not surprising that he was soon engaged to sell compressed medicines for an American company which sent him to London.

#### Founding

Experience in London led Burroughs to invite Wellcome to become his partner in an enterprise there.

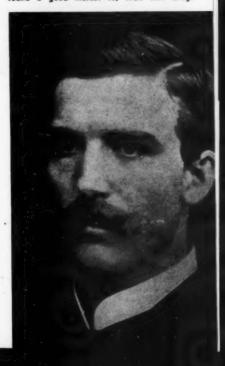
For a long time Wellcome had been impressed with the advantages England had to offer; it not only was the commercial and distributing center for the world, but had extensive libraries, museums and educational institutions. These facilities had a strong appeal for Wellcome, an avid scholar throughout his life.

Wellcome made the trip to England and out of it came the founding of Burroughs Wellcome & Co. in 1880. The partnership was established with a capital of £2000, Burroughs putting in £1200 and Wellcome £800. Profits and losses were to be divided pro rata between them.

The two young Americans made quick headway. They ap-



Siles Burroughs (above) and Henry Wellcome found a good market for their new drugs.



February 1959, Vol. 5, No. 2

rica. with day hilt E.

tion

time

and hip.

icles

har-

hese

in-

tical

into

the

vell, bted & the reious and Cen-

the tive ings can and

the orn Me-

cian



Old Stone Mill, landmark in Westchester, N. Y., became company property in 1926.

plied their pharmaceutical experience in developing the compressed drugs business and became successors to William Brockedon who in 1842 had originated compressed medicines in the shape of biconvex discs. The advantages of this type of medication over the prevalent pill and potion were recognized by Wellcome and he recruited an engineering staff to devise special

machinery for the production of compressed products to a standard of precision never before attempted.

This was a matter of the first importance in view of the increasing use of alkaloids and other highly potent drugs. These compressed medicines could be transported in small bulk and would maintain their full activity under extreme conditions. Their worldin skin disorders

# Decadron

DEXAMETHASONE

treats more patients more effectively

a new order of magnitude in corticosteroid effectiveness a new order of magnitude in margin of safety

Striking clinical results with DECADRON are reported to in 92 percent of 319 patients with dermatological disorders, including cases previously unresponsive or resistant to corticosteroids. There were no major complications, and even minor side effects occurred in less than eight percent of patients.

†Analysis of clinical reports.

Supplied: As 0.75 mg, and 0.5 mg, scored, pentagon shaped tablets in bottles of 100 and 1000.

@1958 Merck & Co., Inc. \*DECADRON is a trademark of Merck & Co., Inc.



926.

of nd-

ore

irst

as-

her

m-

ns-

uld

ler ld-

ian

**MERCK SHARP & DOHME** 

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA

wide distribution afforded a guarantee that a traveler could have his prescription dispensed with the same accuracy and quality wherever he might be.

The new firm did not take long to make itself known. With increased output and wider distribution, the company's compressed products were soon ousting the potion and pill in many markets.

It was not long before branches were opened in most of the principal countries of the world. The U.S. company, Burroughs Wellcome & Co. (U.S.A.) Inc., was established in 1906 and, like the London organization, has both research and manufacturing facilities.

The personalities of Burroughs and Wellcome were quite different, according to those who knew them. It was said that Burroughs was a man of "intense mental, physical and commercial energy, of buoyant individuality and brilliant initiative," while Wellcome was a person with a "steady persistency, capacity for governing and directing others, shrewd judgment and love of executive work and care for detail."

In 1895 Silas Burroughs died from an attack of pneumonia. He had been Wellcome's partner for 15 years and had made a significant contribution to the organization. In addition to being an outstanding businessman, he had proved himself an industrial humanitarian. Because of his strong interest in the welfare of his employees, he introduced the eighthour day at a time when it was considered a Utopian scheme by most employers.

The sudden death of his partner left Henry Wellcome, at the age of 42, with the whole responsibility for an enterprise which had already grown enormously, being represented in most countries of the world, but which under his leadership, was to grow a great deal more. As the company prospered, Wellcome found he had funds to develop many projects.

In 1894 Wellcome had founded The Wellcome Physiological Research Laboratories, the first of many to bear his name. It was obvious to Wellcome that firms such as his must carry out scientific research in their own laboratories.

In 1901 he founded The Wellcome Tropical Research Laboratories at Khartoum for the study of tropical diseases. In 1905 he set up The Wellcome Medical Hospital Dispensary, Uganda. A year later he established a floating research laboratory on the

A serious scholar throughout his life, Wellcome supported two major archaeological expeditions. He is shown at Near East site.

February 1959, Vol. 5, No. 2

gang an had hurong emightwas e by

the ponhich usly, oununow a pany he

undgical first was irms eienora-

velloratudy he lical

oatthe

ician



In 1934 Henry Wellcome (right) received the Remington Honor Medal. Dean H. V. Arny of the New York College of Pharmacy makes the presentation.

Upper Nile for the study of tropical disease.

Of the many distinctive insignia which are associated with pharmaceutical products, few are as widely known as the unicorn emblem which was selected by Henry Wellcome as the general house mark of Burroughs Wellcome & Co. Printed on literature, advertisements, packaging material and embossed on bottle-caps, the "B.W. & Co." unicorn has become a familiar symbol wherever medicinal products are used.

#### Varied interests

After his dream of a world-wide organization had been realized, Wellcome began to free himself from personal attention to detail and to delegate duties to others. This freedom gave him the opportunity to pursue other strong interests.

There was archaeology, for example, and he supported two major archaeological expeditions: one to the Sudan, which he led himself, and the other, more famous, to Palestine. The Greater effectiveness: prompt and sustained relief with fewer doses. Fewer side effects: little or no nausea or vomiting not constipating - LERITINE is spasmolytic minimal unwanted CNS effects—no convulsions or similar neurologic phenomena reported in therapeutic dosage.

TABLETS, 25 mg., in bottles of 100 and 500, PARENTERAL SOLUTION: 25 mg. per cc., in 1-cc. and 2-cc. ampuls; 30-cc. vials. WARNING: May be habit-forming. NOTICE: Subject to Federal Narcotic Law.

# Leriti

orally effective even for

\* LERITIME Is a trademark of Merck & Co., Inc.



MERCK SHARP & DOHME DIVISION OF MERCK & CO., Inc., PHILADELPHIA 1, PA,

rsician

The

, for l two pediwhich other.

on.

vorldreafree ention ties to him other latter, known as the Wellcome-Marston Archaeological Research Expedition to the Near East, investigated an area that is now generally accepted as the site of the Amorite City of Lachish.

He gained a reputation as a collector of objects concerned with medicine and pharmacy which now are part of The Wellcome Foundation Ltd. He was, where medical historical works were concerned, a great bibliophile, and a permanent reminder of this is The Wellcome Historical Medical Library in London.

Wellcome, an important figure in British public life, became a British subject in 1910.

In 1924 he decided to bring together in one unit the many organizations in the various fields of pharmacy and medicine bearing his name, and for this purpose formed The Wellcome Foundation Ltd., a private company with a paid-up capital of one million pounds.

#### Research

When the Wellcome Research Laboratories were founded in 1894 the study of antibody formation was new. The principles which have since been worked out within these laboratories have been fundamental and of incalculable influence in saving lives.

All phases of immunology have been embraced by the Wellcome laboratories. They perfected methods for producing tetanus toxoid and whooping cough vaccine. They enhanced the usability of sera by developing methods to remove the protein fractions that cause anaphylactic reactions, leaving only the one to which the antitoxin is attached.

An important section of their work has been, and continues to be, the investigation of viral diseases; much of it has been on yellow fever. This began with the work of Henry Wellcome himself who was asked by the U.S. Secretary of War, in 1910, to inspect the sanitary conditions in the Panama Canal Zone. His report secured a free hand for General Gorgas to continue his monumental work.

#### Dale

Ergot, long a baffling problem to scientific workers, was subjected to intensive investigation by the Wellcome Research Laboratories, whose director then was the eminent scientist, Dr. Henry H. Dale. These investigations yielded valuable direct results: the discovery of the alkaloid ergotoxine in 1906; p-hydroxyphenylethylamine, in 1909; and the isolation in 1910 of 4-

I

beta

Dale of a difference of the company of the company

the bec An cia as 19 tifi tio aw Hc als

con

lic

of

beta-aminoethylglyoxaline which in the intervening years has proved to be of great interest in relation to anaphylaxis, various shock-like conditions, as well as more recently to the field of allergy.

ave

ome

cted

nus

rac-

bil-

eth-

rac-

re-

to

heir

s to

dis-

on

vith

me

the

10,

ons

His

his

lem

ub-

tion

ab-

hen Dr.

iga-

re-

ka-

hy-

09:

4-

cian

ed.

In pursuing his studies Dr. Dale was fascinated by the effect of a particular extract of ergot on different groups of nerves. His uncovering of the phenomena, revealed by this incident, was the first step toward the modern conception of the transmission of nerve stimuli, a study which earned for him and for Professor Loewi the award of the Nobel Prize in 1936.

The closing years of Wellcome's life witnessed much public recognition of his services in the cause of human welfare. He became a life member of the American Pharmaceutical Association in 1875 and was elected as its honorary president in July 1931. In recognition of his scientific and administrative contributions to pharmacy, Wellcome was awarded the annual Remington Honor Medal in 1934. He was also made an honorary member of the American Society of Tropical Medicine and of the Association of Military Surgeons of the United States. In 1934 he received the honorary degree of



Sir Henry Dale, chairman of trustees, was awarded a Nobel prize in 1936.

doctor of science from Marquette University.

Wellcome also received some of the greatest honors Britain bestows. In 1928 the University of Edinburgh conferred upon him, as a "Princely Patron of Medical Research, a generous friend of missionary enterprise, and an enthusiastic promoter of geographical and archaeological explora-

indecisiveness

when these symptoms point to depression

self depreciation

verreaction to criticism

Dexamyl\*—through its mood-improving and antidepressant action—helps smooth your patient's adjustment to daily living. And, because 'Dexamyl' induces a sense of well-being, it often helps the depressed patient become more responsive to your counselling.

'Dexamyl', a combination of 'Dexedrine' (dextro-amphetamine sulfate, S.K.F.) and amobarbital, is available as tablets, elixir and Spansule\* sustained release capsules.



When listlessness and lethargy accompany depression, Dexedrine's gentle stimulation helps revive normal interest, activity and capacity for work.

> Dexedrine\* is available as tablets, elixir and 'Spansule' sustained release capsules.



\*T.M. Reg. U.S. Pat. Off.

tion," the honorary degree of doctor of laws.

In 1932 King George V knighted Wellcome in recognition of his life's work and generous support of medical research. On the same list to be knighted appeared the name of Dr. Henry H. Dale, now chairman of The Wellcome Trust. A rare distinction was Wellcome's election, also in 1932, as an honorary Fellow of the Royal College of Surgeons.

During a visit to America in 1935 Sir Henry Wellcome became ill and was treated at the Mayo Clinic. In 1936 he returned to England, and, after an operation, died on July 26. His death brought to a close, at the age of 82, a brilliant career.

#### Wellcome trust

Rarely is a whole business undertaking bequeathed to the service of humanity, yet that was the arrangement Wellcome made before he died. Under his will the ownership of the Wellcome Foundation was vested in five trustees.

The aim of the Trust in disposing of the funds accruing from business, in the words of the will, was to be ".... the advancement of research work bearing upon medicine, surgery, chemistry, physiology, bacteriology, therapeutics, materia medica, phar-

macy and allied subjects, and any subject or subjects which have or at any time may develop an importance for scientific research which may conduce to the improvement of the physical conditions of mankind and in particular for the discovery, invention and improvement of medicinal agents and methods for the prevention and cure of disorders and the control or extermination of insects or other pests."

The trustees were also charged with the maintenance of a fund for the establishment or endowment of research museums or libraries in any part of the world and for the collection of information of every kind connected with the history of medicine and allied sciences which in their opinion may be desirable.

A special bequest in the will provided for the erection of cultural facilities in Garden City, Minnesota. This community recently received \$250,000 of a total bequest of \$400,000, which will be used for the construction of a community center.

Though he became the citizen of another country, Henry Well-come remembered the town of his youth, the place where he got his first experience in helping his fellow man, through the profession of pharmacy.

RESIDENT

## Steps up the Pace

Under the directorship of your distinguished editor, Perrin H. Long, M.D., your journal's traditional leadership in editorial standards will be stepped up with a continuing flow of original articles designed to be of practical value to you. Resident Physician recognizes its responsibility of leadership and will continue to bring you editorial "FIRSTS."

THE PUBLISHER

February 1959, Vol. 5, No. 2

157

will cul-City, reof a hich ction tizen Velln of got g his ofes-

ician

any
ye or
imarch
imonditicuntion
cinal
preand
n of

rged fund dow-

orld

and their



# for the common cold... NEW MADRICIDIN

provides in each capsule

**MADRIBON**125 mg
a low-dosage sulfonamide...to help
prevent the secondary bacterial infections which may complicate the
common cold

N-ACETYL-P-AMINOPHENOL 120 mg an analyssic-antipyretic-considered the active metabolite of acetophenetidin...to reduce fever and to relieve headache, myalgia and other discomforts associated with acute respiratory disorders THEPHORIN TARTRATE

10 mg
an antihistamine with low incidence
of side effects... to relieve the
allergy-like congestion, sneezing
and lacrimation which often accompany respiratory infections

CAFFEINE 30 mg a direct-acting physiological stimulant...to allay drowsiness and fatigue and to help combat the "dragged out" feeling of the patient with a common cold

ob

tic



### prompt palliative effect plus defense against secondary invaders

DOSAGE: adults-first day, 2 capsules q.i.d.; 1 capsule q.i.d. thereafter.

children-first day, 2 capsules per 20 lbs body weight; 1 capsule per 20 lbs body weight daily thereafter-given in single or divided doses.

Continue therapy for 5 to 7 days or until patient is asymptomatic for at least 48 hours,

Caution: The usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake. If toxic reactions or blood dyscrasias occur, use of the drug should be discontinued.



10 mg

cidence ve the

eezing

accom-

30 mg

s and

atient

MADRIBONT.M- 2,4-dimethoxy-6-sulfanilamido-1,3-diazine

THEPHORIN® Tartrate—brand of phenindamine tartrate

ROCHE LABORATORIES · Division of Hoffmann-La Roche Inc · Nutley 10 · N. J.

## How to Speak Yiddish

You don't have to be a language expert to handle a medical history and examination of a non-Englishspeaking patient. Here are medical words and phrases to help you break the language barrier.

Yiddish may be more accurately termed a dialect than a language. Developed under Hebrew and Slavic influence from the High German, Yiddish is spoken by Jews in Russia, Central Europe and here in the United States. Since it is written in Hebrew characters, it is seldom seen in this country in its written form. And because it is a dialect, there are many variations, no absolute rules for pronunciation.

RESIDENT PHYSICIAN has attempted to indicate the pronunciation of each word by making up a word in English which, when spoken aloud, should closely approximate the sound of its Yiddish equivalent. Keep in mind that the Yiddish-speaking person is accustomed to hearing many shadings of pronunciation of Yiddish words; he will readily understand your meaning if you pronounce each made-up word just as you would pronounce it if it were a part of the English language.

In the United States, hundreds of thousands of Jews speak Yiddish and one other foreign language. The resident may find that by working back and forth between the two, he will be able to make himself understood with less difficulty.

#### FOR EXAMINATION OF YIDDISH-SPEAKING PATIENTS

#### Three basic rules of pronunciation

ch (when italicized) is aspirated roughly in back of throat (there is no equivalent sound in English).

r also is always pronounced gutterally.

g is always pronounced hard, as g in go, get, great.

#### **Anatomical terms**

head - cup lungs — loongen eyes — oigen shoulders — ahxel ears - oiren back — pleytses — nuz nose arm - orm mouth - moil hands - hant bladder - blahzer teeth - tzayner tongue - tzoong - bine leg - feese throat - gorgle feet finger — finger stomach - muggen neck - haldz rectum tooches chest - broost buttocks ( heart — harts womb gabarmooter

#### Courtesy phrases

Note: Mr., Mrs., and Miss (in their English form) are to be used, but normal courtesy also requires the use of the name after the title, if it is known. If the name is not known, the title is best omitted.

Good morning
Good afternoon
Good night
Please sit down
How are you
Very well, thanks
Do you understand
I understand
Excuse me
Very good

goot morgen
gooten tug
goote nahcht
bitte saitzen see seech
vee gait ess
ah dunk
varstait eer
eech varstay
enshooldigd
sair goot

ian

Today haint
Tomorrow morgen
Yesterday gestern

#### **Directions to patient**

do as I do too vee eech too relax zite ruhig relax more zite mahr ruhig open your mouth affent eere moil open your eyes affent eere oigen breathe deeply ahtemt teef breathe through your mouth ahtemt doorch eere moil hold your breath hult eere ahtem push kvetch cough hoost please don't move bitte hahlten see still

#### **General questions**

do you feel sick een zint krank do you have pain es toot oich vev -much pain ah sahch veytog -mild pain ah bissel veytog where a-voo here duh when van veefeel yurin how many years how many days veefeel tag how many hours veefeel shtoondeh how many times veefeel mohl where were you born voo zint eer geboiren how old are you vee ohlt zint eer

#### Diseases

measles muzlen
scarlet fever scarlatina
chicken pox heener pocken
small pox steln pocken
pneumonia loongen entzeending
typhoid fever teephoos

Sur

rap

tion

Sui

tet

Fo

tet

(ec

(ec

Fe

### when **oral** tetracycline therapy is impractical –



Sumycin Intramuscular provides rapid, sustained antimicrobial activity, when coma, shock, fulminating infection or postoperative complications hamper the administration of Sumycin in the oral form. Concentrations in the blood and tissues reach peak levels for immediate control of tetracycline-sensitive organisms in a broad range of infections.

For immediate therapeutic response -Sumycin Intramuscular with Xylocaine.\* Single dose vials containing tetracycline phosphate complex (equiv. to 250 mg. tetracycline HCl), and single dose vials containing tetracycline phosphate complex (equiv. to 100 mg. tetracycline HCl).

SQUIBB

Flexible dosage forms Tetracycline HCl equivalent (mg.)

Packaging

Capsules (per capsule).250 mg. Bottles of 16 and 100 Half Strength Capsules (per capsule) . . . . . . 125 mg. Bottles of 16 and 100 Syrup (per 5 cc. 60 cc. bottle teaspoonful)......125 mg. a Aqueous Drops (per cc.) . . . . . . . . . 100 mg. 10 cc. bottle with 'FLEXIDOSE' dropper





Squibb Quality-the Priceless Ingredient

SUMYOIN & AND PLEXIDOSE ARE SQUISS TRADEMARKS

<sup>8</sup>7. H.**⑤** ASTRA PHARMADEUTICAL PRODUCTS; INC. FOR LIDOCAIME

sician

enteritis U.R.I. kishke entzeending cult

di w

w

ba

go

u

de

d

cl

fe

d

a

a

Fel

#### Systemic inquiry

Head trauma unconso

unconscious did you faint are you dizzy headache

Eyes

clear vision

far Ears

he is deaf

Nose

coryza did you have a nosebleed

Throat

do you have frequent sore-throat voond gechalisht hut eer gechalisht es shveendelt oich

eer zaite klor

cupvaitig

vait

air ees toib sih kleengt een dee oiren

dee nuz rinnt

gagongin blutt fen nuz

hut eer oft haldz shmarzen

#### .

Pediatrics
did you have trouble with the child's delivery

how are the child's stools

—constipated
—diarrhea

—how many a day does the child eat well

any vomiting
does the child turn blue
does the child seem tired

does it hurt

it will be over in a minute

hut eer gehut shvarikait meet dee keend's geboort wee ees de keend's shtoolgahng

—hart

—loysen muggen

-veefeel een ain tag

duse de keend ass goot bracht de keend weerd de keend bloy ees de keend farmattert toot ass vey

ass werd neecht vey tun
ass weerd zain ariber een ain

minoot

do you want a piece of candy did you take the temperature what was the temperature what a beautiful little girl what a big, handsome boy baby good

veelst dah ah shteekerl chokolat hut eer genoomen de temperature vus ees de temperature see ees a shane madel air ees a shaner ingel klain keend goot

#### **Genito-urinary**

urine do you get up at night to urinate shtate eer uf ba nahcht tzeeh

vasser

lussen vasser

does it burn chills fever

kalt heetz

brennt ess

#### Gastro-intestinal

do you have a good appetite do you have a poor appetite are you nauseated were you nauseated do you vomit do you have diarrhea are you constipated did you have a B.M. today

hut eer ah gooten appeteet hut eer ah shlachten appeteet feelt eer vee tzee brachen hut eer gafeelt vee tzee brachen bracht eer hut eer ah loysen muggen hut eer ah harten muggen hut eer gahut eere shtoolgahng

feces black white yellow brown bloody do you have cramps after meals before meals

did you have a laxative

did you take castor-oil

haint shtoolgahng shvartz vice gail brone bluttick hut eer krahmpfen nuch dam assen aider dam assen

hut eer ganummen ah opferung hut eer ganummen reetzen oil

February 1959, Vol. 5, No. 2

165

t dee hng

in

ysician

#### Cardio-respiratory

do you tire easily are you short of breath does your heart beat fast do your feet swell do you have a pain in the chest -sharp pain

-dull pain do you cough do you spit sputum bloody sputum have you lost weight does someone in your family have a cough

vart eer meed shnall hut eer koorzen ahtem klupt eer harts shnall vayren dee feece gashvollen hut eer veytog in broost -sharf veytog

-neesht sharf eer hoost eer shpit shpyechtz bluttickeh shpyechtz hut eer farloyren vug hut aymeetzer een eere familia ah hoost

#### Obstetrics and gynecology

at what age did you begin to menstruate how many days do you flow 1 to 10

do you have a discharge when was your last menstrual period are you pregnant do you have pains with your periods how many times have you been

pregnant how many children have you had

what was the duration of labor vee lahng hut gadeert dus huben

vee alt gakreegen das monatleeche krahnkhait veefeel tag bluttekt eer ains, zwai, drai, feer, finef, sachs, seeben, ahcht, nun, zane

fleest eer van gavaisen dus lattsteh monatleeche tzite eer shvangert eer hut veytog meet dee monatleeche tzite veefeel mul hut eer geshvangert

veefeel keender hut eer gehut how much did the largest weigh veefeel hut dee graste gavoigen

Febru

WHY RISK DELAYED RECOVERY FROM

# HOSPITAL STAPH'

"Hospital staphylococcus," a frequent cause of antibioticresistant septicemia, enteritis and other serious infections, is most often sensitive to CATHOMYCIN (novobiocin). For the patient with an infection resistant to routine antibiotic therapy, CATHOMYCIN constitutes the first line of defense—it has an established record\* of effectiveness.

CATHOMYCIN may be administered alone or in combination with other antibiotics in full dosage. In combination, it affords protection against the emergence of resistant strains.

Rapidly absorbed, CATHOMYCIN quickly produces high, therapeutic blood levels which are maintained for 12 hours or longer. It is generally well tolerated and does not destroy beneficial intestinal flora. There is no evidence of cross-resistance with other antibiotics.

# CATHOMYCIN

or staphylococcic septicemia, enteritis, postoperative wound fections and other serious staph infections.

NOVOBIOCIN



ichs,

nat-

ert

it

gen

uben

DOSAGE: Adults: CATHOMYCIN Sodium 2 capsules b.i.d. or CATHOMYCIN Calcium Syrup 4 teaspoonfuls b.i.d. Children: (up to 12 years) 2 to 8 teaspoonfuls daily in divided doses based on 10 mg. CATHOMYCIN per lb. of body weight per day. SUPPLIED: Capsules sodium novobiocin, each containing the equivalent of 250 mg. of novobiocin—vials of 16 and 100—and as an orange-flavored syrup (aqueous suspension), in bottles of 60 cc. and 473 cc. (1 pint). Each 5 cc. CATHOMYCIN Syrup contains 125 mg. (2.5%) novobiocin, a scalicium novobiocin. "Complete bibliography available on request.

or Parenteral Therapy LYOVAC® CATHOMYCIN





MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa;

February 1959, Vol. 5, No. 2

167



## Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association.

Answers will be found on page 172

- 1. The malarial parasite which masses in the capillaries of the cerebrum causing pronounced central nervous system symptoms is:
- XA. Plasmodium falciparum.
  - B. Plasmodium malariae.
  - C. Plasmodium knowlesi.
  - D. Plasmodium praecox.
  - E. Plasmodium vivax.
- 2. Massive atelectasis of the right lower lobe on the lateral x-ray film will show the oblique fissure to be:
  - A. Displaced anteriorly.
  - B. Unchanged.
  - C. Displaced posteriorly.
    - D. In a horizontal position.
    - E. Convex anteriorly.

**3.** Which one of the following hernioplasties does *not* entail transplantation of the spermatic cord?

ne le

rms.

Of ature f the fron

A. '

B. ]

enogr

C.K

burth

D.

f lon

E. ]

losure

The

on o

ren is

A. ]

B. 1

C. 1

D. 1

E. (

The

B. 4

C. 2

D. 4

E. 7

Of

he cell

ebruar

ever i

he leg

- Ferguson's repair.
  - B. McArthur's repair.
  - C. Bassini's repair.
  - D. Halsted's repair.
- E. McVey's repair.
- 4. Which of the following statements regarding the frequency of major surgical amputation for Buerger's disease is correct?
- A. The best medical management can eliminate the need for major amputation.
- B. All cases eventually require one or more major amputations.
- C. Major amputation of an upper extremity is required in about 10 percent of cases, of a lower extremity in about 5 percent of cases.
- D. Seventy percent of all cases will eventually require major amputation.
- E. Multiple amputations of

e legs are more common than ngle amputations of hands or rms.

. Of the following, the only ature of benign giant cell tumor the bone which differentiates from solitary bone cyst is:

A. The absence of pain.

ving

ntail

atic

tate-

y of

for

age-

for

re-

outa-

d in

of a

per-

all

of 8

ician

ma-

B. Its pathognomonic roentenographic appearance.

C. Its rarity in the third and ourth decades.

D. Its occurrence at the ends f long bones.

E. Its rarity before epiphyseal osure.

The most frequent complicaon of epidemic typhus in chilren is:

A. Parotitis.

B. Renal Necrosis.

C. Deep venous thrombosis of he legs.

D. Bronchopneumonia. E. Otitis.

fan The total duration of typhoid ever in children is about:

A. 2-3 days.

B. 4-7 days.

C. 2-3 weeks

D. 4-6 weeks.

E. 7-10 weeks.

Of the following alterations in he cellular elements of the blood.



It's so easy to keep the complete financial facts of your practice up-to-date, orderly and readily available for years ... with a Histacount Bookkeeping System.

You'll know, at a glance, what you earned, collected and spent for any day, week, month or year.

It's so easy - no bookkeeping knowledge needed.

Start the New Year right, with the system devised for you.

Send for FREE sample pages and literature.

#### PROFESSIONAL

PRINTING COMPANY, INC. 12 HISTACOUNT BUILDING the only one which is frequently observed after a splenectomy is:

A. A thrombocytopenia.

B. A lymphopenia.

C. A leukopenia.

D. An increase in the reticulocytes.

E. An increase in poikilocy-tosis.

9. If the peripheral blood of a patient who has pernicious anemia is examined when the degree of the anemia is only mild, of the following the abnormality most often present is:

A. Poikilocytosis.

B. Megaloblasts.

C. An increased mean corpuscular hemoglobin concentration.

D. Large multisegmented polymorphonuclear leukocytes.

E. Marked thrombocytopenia.

10. Among the following diseases, the elimination or reduc-

NOTE: If you are interested in preparing questions for "Mediquiz" or the Professional Examination Service, write for information to the Professional Examination Service, 1790 Broadway, New York 19, New York.

your key to

## long acting LEVO-DROMORAN

onset: 5-30 minutes duration: 6-8 hours

# short acting NISENTIL

onset: 5 minutes duration: 2 hours

### versatile PANTOPON

onset: 10-30 minutes duration: 3-6 hours

Levo-Dromoran® Tartrate
Roche (brand of leverphan
tartrate), Nisenti®
Hydrochloride Roche (brand
of alphaprodine hydrochloride)
and Pantopon® Roche may
be habit forming. Narcotic
blank required.

ROCH

Febru

## **ADJUSTED ANALGESIA**

	LEVO-DROMORAN				NISENTIL				PANTOPON		
	1 mg	1-11/2 mg	2 mg	2-3 mg	20 mg	20-30 mg	40 mg	40-60 mg	2.5 mg	5-10 mg	10-20 mg
acute pain		W		SC .							
biliary colic				36.				10			
biopsies					W		*				
burns					W		12				*
Cardiovescular pain								x			
cough control											-
drainage					- IV		9C				
dressings					W		×				
endoscopy						IV					
gangrene				\$5/96							
home care of chronic pain				PO							*
intractable pain				3C/P0							* 9
incisions					W		æ				
labor pain								5C (80 mg)			
major surgery preop.	N		×			36	=				
major surgery postop.			×								
migraine				\$0/96							
minor surgery					N.		sc				
neoplasm				SC/PD							MC.
neuritis				3G/P0							
office procedure						W					
quick analgesia								. 2			
renal colic		.#		-		W		-			
recurrent pain				36,490							
sedation plus analgesia											
trauma		W									



hysician

y to

ROCHE-Reg. U. S. Pat. Off.

\*choice of ampuls, powder,

ROCHE LABORATORIES . Division of Hoffmann-La Roche Inc . Nutley 10 . N. J.

February 1959, Vol. 5, No. 2





Taken at bedtime, pleasanttasting Agoral works gently and effectively, without disturbing sleep, to produce a normal bowel movement the following morning. At the hospital, too, nurses and post-partum patients alike value the convenience and dependability of Agoral. To promote natural bowel function, prescribe nonhabit-forming Agoral.

agoral the gentle laxative



tion of houseflies is of great importance in controlling the spread of;

A. Cholera.

B. Pinworms.

C. Poliomyelitis.

D. Filariasis.

E. Plague.

11. The prevention of dengue is largely a matter of:

 A. Vaccination of the population.

dise

and

ing.

the

fou

of A

ric

Aca

eral

ped

Uni

for

luti

mig

grea

reve

Cli

ciar

Uni

his

Febr

H

I

H

ŀ

H

B. Isolation of cases as soon as discovered.

TC. Adequate mosquito control.

D. Prophylactic antibiotics.

E. Adequate fly control.

12. Convulsions associated with barbiturate administration are most apt to occur when:

A. Barbiturates have been preceded by the use of other drugs.

B. Patients have a history of allergy.

C. More than one form of barbiturate is used.

The drug is withdrawn.

E. The dosage of the drug is suddenly increased.

#### MEDIQUIZ ANSWERS

1 (A), 2 (C), 3 (A), 4 (E), 5 (E), 6 (D), 7 (C), 8 (D), 9 (C), 10 (A), 11 (C), 12 (D).

at imspread What'

### Doctor's Name?

He was the first professor of diseases of children in America and a pioneer of bedside teaching.

He was the first president of the American Pediatric Society, founder of the pediatric section of A.M.A., founder of the pediatric section of the New York Academy of Medicine.

He considered himself a general practitioner rather than a pediatrician.

He received his M.D. from the University of Bonn, was jailed for two years for allegedly revolutionary activities, escaped and migrated to the U.S. with the great German migration after the revolt of 1848.

In 1870 he was appointed Clinical Professor of Diseases of Children at the College of Physicians and Surgeons of Columbia University.

He published two volumes of his writings in 1893 and eight



Fast, potentiated attack on

# URINARY INFECTION

In just a matter of minutes URISED provides four way antibacterial action to relieve genitourinary irritation and smooth muscle spasm . . . to reduce pus cell count . , . to promote mucosal healing.

In just a matter of minutes URISED works to soothe ureteral and urethral spasticity . . . to alleviate discomfort and irritation . . . to restore normal urinary tonus and function,

In cystitis, urethritis, pyelitis, pyelonephritis, ureteritis, acute and chronic infections . . . try this dual-powered, double-fast attack on the primary causes of urinary pain, burning, urgency, dysuria and frequency.

## urised

SUPPLIED: Bottles of 100, 1000 and 2000 tablets.

samples and literature to physicians on request

CHICAGO PHARMACAL COMPANY CHICAGO, ILLINOIS

February 1959, Vol. 5, No. 2

173

opulas soon

igue is

con-

d with

been

tory d

wn.

s

drug is

), 6 (D), 11 (C),

hysician

large volumes in 1909. His most important subjects were diphtheria and the feeding and care of children.

He attacked the raising of children in institutions, regardless of what could be done for them there, and was expelled from the Nursery and Child's Hospital, where he was chief of staff.

He was one of the founders in New York of Mt. Sinai Hospital and of German Dispensary, now known as Lenox Hill Hospital.

He and philanthropist Nathan Straus established the first free milk station for the babies of indigent mothers. He established the first preventorium for tuberculosis in infants.

He was showered with honors in his lifetime, including the naming of a 70-bed pediatric division at Lenox Hill Hospital after him, many honorary university degrees and, in 1911, presidency of A.M.A.

In his 88th year he escaped death when his summer cottage was destroyed by fire. He suffered from severe shock and in the next year, 1919, he died. Can you name this doctor?

Answer on page 181.

Placidyl nudges your patient to sleep

abbott